

Title 284 WAC

INSURANCE

COMMISSIONER, OFFICE OF

Chapters

284-07	Requirements as to company reports and annual statements.
284-23	Washington life insurance regulations.
284-24	Rates.
284-24A	Rules that apply to insurers that use credit history for personal insurance underwriting or rating.
284-24D	Medical malpractice closed claim data reporting rules for facilities and providers.
284-24E	Medical malpractice claim settlement data reporting rules for attorneys and claimants.
284-30	Trade practices.
284-37	Market conduct oversight program.
284-43	Health carriers and health plans.
284-50	Washington disability insurance regulations.
284-51	Standards for coordination of benefits.
284-66	Washington Medicare supplement insurance regulation.
284-96	Group and blanket disability insurance.

Chapter 284-07 WAC

REQUIREMENTS AS TO COMPANY REPORTS AND ANNUAL STATEMENTS

WAC

284-07-050	Financial statement instructions.
284-07-310	Purpose.
284-07-330	Scope.
284-07-340	Definitions.
284-07-350	General requirements.
284-07-380	Statement of actuarial opinion based on an asset adequacy analysis.
284-07-390	Description of actuarial memorandum including an asset adequacy analysis and regulatory asset adequacy issues summary.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-07-360	Required opinions. [Statutory Authority: RCW 48.01.-030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.-260. 95-02-036 (Order R 94-26), § 284-07-360, filed 12/30/94, effective 1/30/95.] Repealed by 08-01-077 (Matter No. R 2006-10), filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060, 48.74.-025, 48.36A.250, 48.36A.260.
284-07-370	Statement of actuarial opinion not including an asset adequacy analysis. [Statutory Authority: RCW 48.01.-030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.-260. 95-02-036 (Order R 94-26), § 284-07-370, filed 12/30/94, effective 1/30/95.] Repealed by 08-01-077 (Matter No. R 2006-10), filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060, 48.74.-025, 48.36A.250, 48.36A.260.

WAC 284-07-050 Financial statement instructions.

(1) For the purpose of this section, the following definitions shall apply:

(a) "Insurer" shall have the same meaning as set forth in RCW 48.01.050. It also includes health care service contractors registered under chapter 48.44 RCW and health maintenance organizations registered under chapter 48.46 RCW, and fraternal benefit societies registered under chapter 48.36A RCW.

(b) "Insurance" shall have the same meaning as set forth in RCW 48.01.040. It also includes prepayment of health care services as set forth in RCW 48.44.010(3) and prepayment of comprehensive health care services as set forth in RCW 48.46.020(1).

(2) Each authorized insurer is required to file with the commissioner an annual statement for the previous calendar year in the general form and context as promulgated by the National Association of Insurance Commissioners (NAIC) for the kinds of insurance to be reported upon, and shall also file a copy thereof with the NAIC. To effectuate RCW 48.05.250, 48.05.400, 48.36A.260, 48.44.095 and 48.46.080 and to enhance consistency in the accounting treatment accorded various kinds of insurance transactions, the valuation of assets, and related matters, insurers shall adhere to the appropriate Annual Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC.

(3) This section does not relieve an insurer from its obligation to comply with specific requirements of the insurance code or rules.

(4) Annual statements:

(a) Annual statements for all domestic insurers must be filed electronically with the commissioner. Insurers must electronically transmit the annual statement, as described in subsection (2) of this section, in PDF or other format as noted on the commissioner's web site. The commissioner has the discretion to allow an insurer to file annual statements on paper. The insurer must demonstrate that filing in electronic form will create an undue financial hardship for the insurer. Applications for permission to file on paper must be received by the commissioner at least ninety days before the annual statement is due.

(b) To comply with statutory requirements that annual statements must be verified by the oaths of at least two of the insurer's officers, insurers may:

(i) Use a method of electronic signature verification that has been approved by the commissioner for use by the insurer; or

(ii) File a paper copy of the signature and jurat page of the annual statement at the time of the electronic filing of the annual statement. This paper copy must contain the original signature of the company officers and the notary administering the oath.

(c) Both the electronic annual statement and the verification of that statement by the oaths of two officers must be received by the commissioner to complete an annual statement filing. The date of receipt of the later of the electronic

annual statement or verification is considered the receipt date of the annual statement.

(5)(a) Each domestic insurer shall file quarterly statements of its financial condition with the commissioner and with the NAIC. Each foreign insurer shall file quarterly statements of its financial condition with the NAIC. The commissioner may require a foreign insurer to file quarterly statements with the commissioner whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the foreign insurer. The statements shall be filed in the commissioner's office not later than the forty-fifth day or the fifteenth day of the second month after the end of the insurer's calendar quarters, whichever is later. The quarterly statements shall be in the form and content as promulgated by the NAIC for quarterly reporting by insurers, shall be prepared according to appropriate Annual and Quarterly Statement Instructions and the Accounting Practices and Procedures Manuals promulgated by the NAIC and shall be supplemented with additional information required by this title and by the commissioner. Quarterly statements for the fourth quarter are not required.

(b) Quarterly statements must be filed with the commissioner by electronically transmitting the quarterly statement as described in this subsection, in PDF or other format as noted on the commissioner's web site.

(6) As a part of any investigation by the commissioner, the commissioner may require an insurer to file monthly financial statements whenever, in the commissioner's discretion, there is a need to more closely monitor the financial activities of the insurer. Monthly financial statements shall be filed in the commissioner's office no later than the twenty-fifth day of the month following the month for which the financial statement is being filed. Such monthly financial statements shall be the internal financial statements of the company. In addition, the commissioner may require these internal financial statements to be accompanied by a schedule converting the financial statements to reflect financial position according to statutory accounting practices and submitted in a form using the same format and designation as the insurer's quarterly financial statements of insurers. "Financial statements" as used in this subsection includes:

- (a) Statement of assets;
- (b) Liabilities, capital and surplus;
- (c) Statements of revenue and expenses; and
- (d) Statements of cash flows.

(7) Health care service contractors shall use the Health Statement Form promulgated by the NAIC for their statutory filings.

(8) Each health care service contractor's and health maintenance organization's annual statement shall be accompanied by an additional data statement form (IC-13A-HC/IC-14-HMO).

(9) The commissioner may allow a reasonable extension of the time for filing the financial statements. A request for an extension must be in writing. The request must be received prior to the due date of the filing and must state good cause for the extension. An extension can only be granted in writing; paper, fax, or e-mail is considered "writing" for purposes of this subsection.

[Statutory Authority: RCW 48.02.060, 48.44.500, and 48.46.200. 07-14-104 (Matter No. R 2007-04), § 284-07-050, filed 7/2/07, effective 8/2/07. Statu-

tory Authority: RCW 48.02.060, 48.44.050, and 48.46.200. 02-21-120 (Matter No. R 2002-07), § 284-07-050, filed 10/23/02, effective 11/23/02. Statutory Authority: RCW 48.02.060, 48.05.073, 48.44.050, 48.46.200. 01-11-077 (Matter No. R 2000-09), § 284-07-050, filed 5/15/01, effective 6/15/01. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 99-16-035 (Matter No. R - 99-3), § 284-07-050, filed 7/28/99, effective 8/28/99; 96-17-079 (Matter No. R 95-18), § 284-07-050, filed 8/21/96, effective 9/21/96. Statutory Authority: RCW 48.02.060. 92-19-040 (Order R 92-10), § 284-07-050, filed 9/9/92, effective 10/10/92.]

WAC 284-07-310 Purpose. The purpose of this regulation, WAC 284-07-310 through and including WAC 284-07-400, called the actuarial opinion and memorandum regulation, is to prescribe:

(1) Guidelines and standards for statements of actuarial opinion submitted in accordance with the requirements of RCW 48.74.025, 48.36A.250, 48.36A.260, and for supporting memoranda;

(2) Rules applicable to the appointment of an appointed actuary; and

(3) Guidelines and standards relating to "adequacy of reserves."

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260. 08-01-077 (Matter No. R 2006-10), § 284-07-310, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-310, filed 12/30/94, effective 1/30/95.]

WAC 284-07-330 Scope. (1) This regulation applies to all life insurance companies and fraternal benefit societies doing business in this state, to all life insurance companies and fraternal benefit societies which are authorized to reinsure life insurance, annuities, or disability insurance business in this state; and to all disability insurers that file annual statements on the life and accident and health blank. This regulation requires the appointed actuary to use his or her professional judgment in performing the required asset analysis and developing the actuarial opinion and supporting memoranda, consistent with relevant actuarial standards of practice. The commissioner may specify specific methods of actuarial analysis and actuarial assumptions when, in the commissioner's opinion, such specifications are necessary.

(2) This regulation applies to all annual statements filed with the commissioner on and after December 31, 2007.

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260. 08-01-077 (Matter No. R 2006-10), § 284-07-330, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-330, filed 12/30/94, effective 1/30/95.]

WAC 284-07-340 Definitions. The following definitions apply throughout this regulation:

(1) "Actuarial opinion" means the opinion of an appointed actuary regarding the adequacy of the reserves and related actuarial items based on an asset adequacy analysis set forth in WAC 284-07-380 and according to applicable actuarial standards of practice.

(2) "Actuarial Standards Board" means the board established by the American Academy of Actuaries to develop and promulgate standards of actuarial practice.

(3) "Annual statement" means that statement required by RCW 48.05.250 to be filed annually by the company with the commissioner.

(4) "Appointed actuary" means any individual who is appointed or retained in accordance with the requirements set forth in WAC 284-07-350(3) to provide the actuarial opinion and supporting memorandum as required by RCW 48.74-.025.

(5) "Asset adequacy analysis" means an analysis that meets the standards and other requirements set forth in WAC 284-07-350(4).

(6) "Company" means an insurance company, fraternal benefit society, or reinsurer subject to this regulation.

(7) "Qualified actuary" means an individual who meets the requirements set forth in WAC 284-07-350(1).

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-340, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260, 95-02-036 (Order R 94-26), § 284-07-340, filed 12/30/94, effective 1/30/95.]

WAC 284-07-350 General requirements. The statement of opinion on the adequacy of the reserves and related actuarial items based on an asset adequacy analysis in accordance with WAC 284-07-380, and a memorandum in support thereof in accordance with WAC 284-07-390, are required each year.

Statement of actuarial opinion:

(1) "Qualified actuary" means an individual who:

(a) Is a member in good standing of the American Academy of Actuaries; and

(b) Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements or equivalent standards acceptable to the commissioner; and

(c) Is familiar with the valuation requirements applicable to life and health insurance companies; and

(d) Has not been found by the commissioner (or if so found has subsequently been reinstated as a qualified actuary), following appropriate notice to have:

(i) Violated any provision of, or any obligation imposed by, Title 48 RCW or other law or any applicable regulation or order of the commissioner in the course of his or her dealings as a qualified actuary;

(ii) Been found guilty of fraudulent or dishonest practices;

(iii) Demonstrated his or her incompetence, lack of cooperation, or untrustworthiness to act as a qualified actuary;

(iv) Submitted to the commissioner during the past five years, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this regulation or standards set by the Actuarial Standards Board; or

(v) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and

(e) Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under (d) of this subsection.

(f) The commissioner may accept equivalent qualifications in place of those in (a) and (b) of this subsection if the

individual has otherwise demonstrated his or her actuarial competence to the satisfaction of the commissioner, and meets the qualifications in (c), (d), and (e) of this subsection.

(2) "Appointed actuary" means a qualified actuary who is appointed or retained to prepare the statement of actuarial opinion required by this regulation; either directly by, or by the authority of, the board of directors through an executive officer of the company.

(a) The company shall give the commissioner timely written notice of the following: The name, title (and, in the case of a consulting actuary, the name of the firm), and manner of appointment or retention of each person appointed or retained by the company as an appointed actuary.

(b) The company must state in its notice that the appointed actuary meets the requirements set forth in subsection (1) of this section.

(c) After the company furnishes the notice, no further notice is required with respect to this person, except the following, if applicable:

(i) The company must give the commissioner timely written notice if the actuary ceases to be appointed or retained as an appointed actuary; and

(ii) The company must give the commissioner timely written notice if the actuary fails to meet the requirements set forth in subsection (2) of this section.

(d) If any person appointed or retained as an appointed actuary replaces a previously appointed actuary, the notice must include that information and give the reasons for replacement.

(3) Standards for asset adequacy analysis: Unless the commissioner approves equivalents in advance, the asset adequacy analysis required by this regulation:

(a) Must conform to the standards of practice as promulgated from time to time by the Actuarial Standards Board and to any additional standards under this regulation, and must form the basis of the statement of actuarial opinion in accordance with this regulation; and

(b) Must be based on methods of analysis that are deemed appropriate for such purposes by the Actuarial Standards Board.

(4) Liabilities to be covered:

(a) As required by RCW 48.74.025, the statement of actuarial opinion applies to all in force business on the statement date regardless of when or where issued, including reserves of Exhibits 5, 6, and 7, and claim liabilities in Exhibit 8, Part 1 and equivalent items in the separate account statement or statements.

(b) If the appointed actuary determines as the result of asset adequacy analysis that a reserve should be held in addition to the aggregate reserve held by the company calculated in accordance with methods set forth in RCW 48.74.040, 48.74.070, 48.74.080, and 48.74.090, the company must establish the appropriate additional reserve.

(c) Additional reserves established under (b) of this subsection and deemed not necessary in subsequent years may be released. Any amounts released must be disclosed in the actuarial opinion for the applicable year. The release of these reserves will not be deemed an adoption of a lower standard of valuation.

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-350, filed 12/17/07, effective

1/17/08. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260. 95-02-036 (Order R 94-26), § 284-07-350, filed 12/30/94, effective 1/30/95.]

WAC 284-07-380 Statement of actuarial opinion based on an asset adequacy analysis. (1) General description: The statement of actuarial opinion must include the following:

(a) A paragraph identifying the appointed actuary and his or her qualifications (see subsection (2)(a) of this section);

(b) A scope paragraph identifying the subjects on which an opinion is to be expressed and describing the scope of the appointed actuary's work, including a tabulation delineating the reserves and related actuarial items which have been analyzed for asset adequacy and the method of analysis, (see subsection (2)(b) of this section) and identifying the reserves and related actuarial items covered by the opinion which have not been so analyzed;

(c) A reliance paragraph describing those areas, if any, where the appointed actuary has deferred to other experts in developing data, procedures or assumptions, e.g., anticipated cash flows from currently owned assets, including variation in cash flows according to economic scenarios (see subsection (2)(c) of this section), supported by a statement of each expert relied on in the form prescribed by subsection (5) of this section; and

(d) An opinion paragraph expressing the appointed actuary's opinion concerning the adequacy of the supporting assets to mature the liabilities (see subsection (2)(f) of this section).

(e) One or more of the following paragraphs will be needed in individual company cases, as follows:

(i) If the appointed actuary considers it necessary to state a qualification of his or her opinion;

(ii) If the appointed actuary must disclose the method of aggregation for reserves of different products or lines of business for asset adequacy analysis;

(iii) If the appointed actuary must disclose an inconsistency in the method of analysis or basis of asset allocation used at the prior opinion date with that used for this opinion;

(iv) If the appointed actuary must disclose whether additional reserves of the prior opinion date are released as of this opinion date, and the extent of the release; or

(v) If the appointed actuary chooses to add a paragraph briefly describing the assumptions which form the basis for the actuarial opinion.

(2) Recommended language: The following paragraphs must be included in the statement of actuarial opinion in accordance with this section. Language is that which in typical circumstances shall be included in a statement of actuarial opinion. The language may be modified as needed to meet the circumstances of a particular case, but the appointed actuary must clearly express his or her professional judgment. In any event, the opinion must include all pertinent aspects of the language provided in this section.

(a) The opening paragraph must generally state the appointed actuary's relationship to the company and his or her qualifications to sign the opinion.

(i) For a company actuary, the opening paragraph of the actuarial opinion must read substantially as follows:

"I, [name], am [title] of [insurance company name] and a member of the American Academy of Actuaries. I was appointed by, or by the authority of, the Board of Directors of that company to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability insurance companies."

(ii) For a consulting actuary, the opening paragraph must contain a statement substantially similar to the following:

"I, [name], a member of the American Academy of Actuaries, am associated with the firm of [name of consulting firm]. I have been appointed by, or by the authority of, the Board of Directors of [name of company] to render this opinion as stated in the letter to the Commissioner dated [insert date]. I meet the Academy qualification standards for rendering the opinion and am familiar with the valuation requirements applicable to life and disability insurance companies."

(b) The scope paragraph must include a statement substantially similar to the following:

"I have examined the actuarial assumptions and actuarial methods used in determining reserves and related actuarial items listed below, as shown in the annual statement of the company, as prepared for filing with state regulatory officials, as of December 31, 20[]. Tabulated below are those reserves and related actuarial items which have been subjected to asset adequacy analysis."

Asset Adequacy Tested Amounts				Reserves and Liabilities	
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1) + (2) + (3) (4)
Exhibit 5					
A Life Insurance					
B Annuities					
C Supplementary Contracts With Life Contingencies					
D Accidental Death Benefit					
E Disability - Active					
F Disability - Disabled					
G Miscellaneous					

Asset Adequacy Tested Amounts				Reserves and Liabilities	
Statement Item	Formula Reserves (1)	Additional Actuarial Reserves (a) (2)	Analysis Method (b)	Other Amount (3)	Total Amount (1) + (2) + (3) (4)
Total (Exhibit 5 Item 1, Page 3)					
Exhibit 6					
A Active Life Reserve					
B Claim Reserve					
Total (Exhibit 6 Item 2, Page 3)					
Exhibit 7					
Premiums and Other Deposit Funds (Column 6, Line 14)					
Guaranteed Interest Contracts (Column 2, Line 14)					
Annuities Certain (Column 3, Line 14)					
Supplemental Contracts (Column 4, Line 14)					
Dividend Accumulations or Refunds (Column 5, Line 14)					
Total (Exhibit 7, Item 3, Page 3)					
Exhibit 8 Part 1					
1 Life (Page 3, Line 4.1)					
2 Health (Page 3, Line 4.2)					
Total Exhibit 8, Part 1					
Separate Accounts (Page 3 of the Annual Statement of the Separate Accounts, Lines 1 and 2)					
TOTAL RESERVES					

IMR (General Account, Page 3, Line 9.4)	
IMR (Separate Accounts, Page 3, Line 3)	
AVR (Page 3, Line 24.1)	(c)
Net Deferred and Uncollected Premium	

Notes to table of reserves and related actuarial items:

Page and line numbers refer to the 2005 blank. Corresponding entries from blanks from later years are to be substituted as appropriate.

- The additional actuarial reserves are the reserves established under WAC 284-07-350 (5)(b).
- The appointed actuary must state the method of analysis, determined in accordance with the standards for asset adequacy analysis referred to in WAC 284-07-350(4), by means of symbols which shall be defined in footnotes to the table.
- Allocated amount of Asset Valuation Reserve (AVR)."

(c) If the appointed actuary has relied on other experts to develop any portion of the analysis, the reliance paragraph must include a statement substantially similar to the following:

"I have relied on [name], [title] for [e.g., anticipated cash flows from currently owned assets, including variations in cash flows according to economic scenarios, or certain critical aspects of the analysis performed in conjunction with forming my opinion] as certified in the attached statement. I have reviewed the information relied upon for reasonableness."

A statement of reliance on other experts must be accompanied by a statement by each expert in the form prescribed by subsection (5) of this section.

(d) If the appointed actuary has examined the underlying asset and liability records, the reliance paragraph must also include substantially the following statement:

"My examination included a review of the actuarial assumptions, actuarial methods, the underlying basic asset and liability records, and other tests of the actuarial calculations I considered necessary. I also reconciled

the underlying basic asset and liability records to [exhibits and schedules listed as applicable] of the company's current annual statement."

(e) If the appointed actuary has not examined the underlying records, but has relied upon listings or summaries of policies in force, or asset records, or both prepared by the company, the reliance paragraph must include a statement substantially similar to the following:

"In forming my opinion on [specify types of reserves] I relied upon data prepared by [name and title of company officer certifying in-force records or other data] as certified in the attached statements. I evaluated that data for reasonableness and consistency. I also reconciled that data to [exhibits and schedules to be listed as applicable] of the company's current annual statement. In other respects my examination included review of the actuarial assumptions and actuarial methods used and tests of the actuarial calculations I considered necessary."

The paragraph must be accompanied by a signed statement by each person relied upon based on the form set forth in subsection (5) of this section.

(f) The opinion paragraph must include a statement substantially similar to the following:

"In my opinion the reserves and related actuarial values concerning the statement items identified above:

- (i) Are computed in accordance with presently accepted actuarial standards consistently applied and are fairly stated, in accordance with sound actuarial principles;
- (ii) Are based on actuarial assumptions which produce reserves at least as great as those called for in any contract provision as to reserve basis and method, and are in accordance with all other contract provisions;
- (iii) Meet the requirements of the insurance laws and regulations of the state of [state of domicile] and are at least as great as the minimum aggregate amounts required by the state in which this statement is filed;
- (iv) Are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the preceding year-end (with any exceptions noted below);
- (v) Include provision for all actuarial reserves and related statement items which ought to be established.

The reserves and related items, when considered in light of the assets held by the company with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on the assets, and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the company.

The actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the

Actuarial Standards Board, which standards form the basis of this statement of opinion.

This opinion is updated annually as required by statute. To the best of my knowledge, there have been no material changes from the applicable date of the annual statement to the date of the rendering of this opinion which should be considered in reviewing this opinion.

or

The following material change(s) which occurred between the date of the statement for which this opinion is applicable and the date of this opinion should be considered in reviewing this opinion: (Describe the change or changes.)

The impact of unanticipated events subsequent to the date of this opinion is beyond the scope of this opinion. The analysis of asset adequacy portion of this opinion should be viewed recognizing that the company's future experience may not follow all the assumptions used in the analysis.

Signature of Appointed Actuary

Address of Appointed Actuary

Telephone Number of Appointed Actuary

Date"

(3) Assumptions for new issues: The adoption for new issues or new claims or other new liabilities of an actuarial assumption which differs from a corresponding assumption used for prior new issues or new claims or other new liabilities is not a change in actuarial assumptions within the meaning of this section.

(4) Adverse opinions: If the appointed actuary is unable to form an opinion, then he or she must refuse to issue a statement of actuarial opinion. If the appointed actuary's opinion is adverse or qualified, then he or she must issue an adverse or qualified actuarial opinion explicitly stating the reason(s) for the adverse opinion. This statement must follow the scope paragraph and precede the opinion paragraph.

(5) Reliance on data furnished by other persons: If the appointed actuary does not express an opinion as to the accuracy and completeness of the listings and summaries of policies in force or if the actuary relies on the certification of others on matters concerning the accuracy or completeness of any data underlying the actuarial opinion, or the appropriateness of any other information used by the appointed actuary in forming the actuarial opinion, the actuarial opinion must include the names of the persons the actuary is relying upon and a precise identification of the items subject to reliance. In addition, the persons on whom the appointed actuary relies must provide a certification that precisely identifies the items on which the person is providing information and a statement as to the accuracy, completeness or reasonableness of the items, as applicable. This certification must include the signature, title, company's legal name, address and telephone number of the person providing the certification, and the date on which it is signed. This certification must include the reporting date, the name of the appointed actuary, and must

be attached to the opinion, in a form substantially similar to the following:

"I [name of officer], [title], of [name of company], hereby affirm that the listings and summaries of policies and contracts in force as of December 31, 20[], and other liabilities prepared for and submitted to [name of appointed actuary] were prepared under my direction and, to the best of my knowledge and belief, are substantially accurate and complete.

Signature of the Officer of the Company

Address of the Officer of the Company

Telephone Number of the Officer of the Company

Date"

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-380, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.02.060, 06-12-077 (Matter No. R 2006-04), § 284-07-380, filed 6/6/06, effective 7/7/06. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260, 95-02-036 (Order R 94-26), § 284-07-380, filed 12/30/94, effective 1/30/95.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-07-390 Description of actuarial memorandum including an asset adequacy analysis and regulatory asset adequacy issues summary. (1)(a) In accordance with RCW 48.74.025, the appointed actuary must prepare a memorandum to the company describing the analysis done in support of his or her opinion regarding the reserves. The memorandum must be made available for examination by the commissioner upon his or her request but will be returned to the company after the examination and will not be considered a record of the commissioner or subject to automatic filing with the commissioner.

(b) In preparing the memorandum, the appointed actuary may rely on, and include as a part of his or her own memorandum, memoranda prepared and signed by other actuaries who are qualified within the meaning of WAC 284-07-350(2), with respect to the areas covered in such memoranda, and must include a statement to that effect in their memoranda.

(c) If the commissioner requests a memorandum and an adequate memorandum is not provided within ten days after the request, or, if the commissioner finds that the analysis described in the memorandum fails to meet the standards of the Actuarial Standards Board or the standards and requirements of this regulation, the commissioner may designate a qualified actuary to review the opinion and prepare the supporting memorandum required for review. All reasonable and necessary expenses of the independent review must be paid by the company but all expenses related to the review will be directed and controlled by the commissioner.

(d)(i) The reviewing actuary must have the same status as an examiner for purposes of obtaining data from the company and the work papers and documentation of the reviewing actuary must be retained by the commissioner. Information provided by the company to the reviewing actuary and included in the work papers will be considered material pro-

vided by the company to the commissioner and will be kept confidential to the same extent as prescribed by law with respect to other material provided by the company to the commissioner.

(ii) The reviewing actuary must not be an employee of a consulting firm involved with the preparation of any prior memorandum or opinion for the company for the current year or any one of the preceding three years.

(e) In accordance with RCW 48.74.025, the appointed actuary must prepare a regulatory asset adequacy issues summary according to the requirements set forth in subsection (3) of this section. The regulatory asset adequacy issues summary must be submitted no later than March 15 of the year following the year for which a statement of actuarial opinion based on asset adequacy is required. Except for a domestic life insurance company, the regulatory asset adequacy issues summary must be submitted only upon request of the commissioner. The regulatory asset adequacy issues summary has the standing of a memorandum in support of the actuarial opinion, and will be kept confidential to the extent and under the conditions provided for in RCW 48.74.025(4).

(2) When an actuarial opinion is provided, the memorandum must demonstrate that the analysis has been completed in accordance with the standards for asset adequacy set forth in WAC 284-07-350(4) and any additional standards required by the commissioner. The memorandum must include the following:

(a) For reserves:

(i) Product descriptions including market description, underwriting and other aspects of a risk profile, and the specific risks the appointed actuary deems significant;

(ii) Sources of liabilities in force;

(iii) Reserve methods and bases;

(iv) Investment reserves;

(v) Reinsurance arrangements;

(vi) Identification of any explicit or implied guarantees made by the general account in support of benefits provided through a separate account or under a separate account policy or contract and the methods used by the appointed actuary to provide for the guarantees in the asset adequacy analysis;

(vii) Documentation of assumptions, including comparisons with experience, to test reserves for the following:

(A) Lapse rates, both base and excess;

(B) Interest crediting rate strategy;

(C) Mortality;

(D) Policyholder dividend strategy;

(E) Competitor or market interest rate;

(F) Annuitization rates;

(G) Commissions and expenses; and

(H) Morbidity.

The documentation of the assumptions must allow an actuary reviewing the actuarial memorandum to form a conclusion regarding the reasonableness of the assumptions.

(b) For assets:

(i) Portfolio descriptions, including a risk profile disclosing the quality, distribution, and types of assets;

(ii) Investment and disinvestment assumptions;

(iii) Sources of asset data;

(iv) Asset valuation bases;

(v) Documentation of assumptions made for:

(A) Default costs;

- (B) Bond call function;
- (C) Mortgage prepayment function;
- (D) Determining market value for assets sold due to disinvestment strategy; and
- (E) Determining yield on assets acquired through the investment strategy.

The documentation of the assumptions must allow an actuary reviewing the actuarial memorandum to form a conclusion regarding the reasonableness of the assumptions.

(c) Analysis basis:

- (i) Methodology;
- (ii) Rationale for inclusion or exclusion of different blocks of business and how pertinent risks were analyzed;
- (iii) Rationale for degree of rigor in analyzing different blocks of business, including the level of "materiality" that was used in determining how rigorously to analyze different blocks of business;

(iv) Criteria for determining asset adequacy, including the precise basis for determining if assets are adequate to cover reserves under "moderately adverse conditions" or other conditions, as specified in relevant actuarial standards of practice;

(v) Consideration of the impact of federal income taxes; and

(vi) The method of treating reinsurance in the asset adequacy analysis.

(d) Sensitivity testing: Impact of changes in assumptions used in asset adequacy analysis, based on sensitivity tests performed.

(e) Material changes: Summary of material changes in methods, procedures, or assumptions from prior year's asset adequacy analysis.

(f) Results:

(i) Schedules under each required scenario showing the cash flows by each of the major items of income, benefits, and expenses, statutory gains or losses, and statutory balance sheet, as modeled, for each year in the projection period; and

(ii) Summary of results.

(g) Conclusion(s).

(3) The regulatory asset adequacy issues summary must contain the name of the company for which the regulatory asset adequacy issues summary is being supplied and must be signed and dated by the appointed actuary providing the actuarial opinion. The regulatory asset adequacy issues summary must include all of the following:

(a) Descriptions of the scenarios tested, including whether those scenarios are stochastic or deterministic, and the sensitivity testing performed relative to those scenarios.

(i) If certain tests produce negative ending surplus in the aggregate, the actuary must describe those tests and state the amount of additional reserve as of the valuation date that, if held, would eliminate the negative aggregate surplus values.

(ii) The actuary must determine ending surplus values by either:

(A) Extending the projection period until the in force and associated assets and liabilities at the end of the projection period are immaterial; or

(B) Adjusting the surplus amount at the end of the projection period by an amount that appropriately estimates the value that can reasonably be expected to arise from the assets and liabilities remaining in force.

(b) An explanation of the extent to which the appointed actuary uses assumptions in the asset adequacy analysis that are materially different from the assumptions used in the previous asset adequacy analysis.

(c) A description of the amount of reserves and the identity of the product lines that had been subjected to asset adequacy analysis in the prior opinion but were not subject to analysis for the current opinion.

(d) Comments on any interim results that may be of significant concern to the appointed actuary.

(e) The methods used by the actuary to recognize the impact of reinsurance on the company's cash flows, including both assets and liabilities, under each of the scenarios tested.

(f) A paragraph explaining whether the actuary is satisfied that all options whether explicit or embedded, in any asset or liability (including but not limited to those affecting cash flows embedded in fixed income securities) and equity-like features in any investments have been appropriately considered in the asset adequacy analysis.

(4) The memorandum must include a statement substantially similar to the following:

"Actuarial methods, considerations, and analyses used in the preparation of this memorandum conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, which standards form the basis for this memorandum."

[Statutory Authority: RCW 48.02.060, 48.74.025, 48.36A.250, 48.36A.260, 08-01-077 (Matter No. R 2006-10), § 284-07-390, filed 12/17/07, effective 1/17/08. Statutory Authority: RCW 48.01.030, 48.02.060, 48.74.025, 48.36A.250 and 48.36A.260, 95-02-036 (Order R 94-26), § 284-07-390, filed 12/30/94, effective 1/30/95.]

Chapter 284-23 WAC

WASHINGTON LIFE INSURANCE REGULATIONS

WAC

284-23-580

Insurer must obtain and keep evidence that insured is a key person—Definition of "key person."

WAC 284-23-580 Insurer must obtain and keep evidence that insured is a key person—Definition of "key person." (1) If a business entity seeks to be the owner and beneficiary of a contract of life insurance on an employee, the insurer must obtain and keep evidence that the business entity had an "insurable interest" in the life of the insured as required by RCW 48.18.030(3) and that the insured was a "key person" at the time the contract was made.

(2) An insurer issuing employer-owned key person life insurance to a business entity shall establish and apply appropriate underwriting guidelines to ensure that the employees or other persons on whose lives key person life insurance policies are written are actually key persons.

(3) An insurer issuing employer-owned life insurance policies or certificates must keep or require the employer to keep throughout the period of insurance, evidence that the insured has applied for or consented to the contract in writing. Consent requirements include, but are not limited to RCW 48.18.030, 48.18.060, and 48.18.580.

(4) If a contract of insurance is entered into pursuant to an exchange under Section 1035 of the Internal Revenue Code, an insurer is not required to obtain a new consent by

the insured employee (as required at RCW 48.18.580(2)) only if the insurer to be replaced provides the replacing insurer with a copy of the original signed consent.

(5) The term "key person" means a person that, during the year the contract was made, was:

- (a) A director;
- (b) A shareholder who owns more than five percent in value of the stock of the employer; or
- (c) A "highly compensated individual" or "highly compensated employee" within the meaning of Internal Revenue Code sections 414(q), 105(h) or 101(j), as applicable.

[Statutory Authority: RCW 48.02.060 and 48.18.586. 08-01-076 (Matter No. R 2004-03), § 284-23-580, filed 12/17/07, effective 1/17/08.]

Chapter 284-24 WAC

RATES

WAC

284-24-120 Suspension of rate filing requirements—Large commercial accounts.

WAC 284-24-120 Suspension of rate filing requirements—Large commercial accounts. (1) Under RCW 48.19.080, the rate filing requirements in chapter 48.19 RCW are suspended with respect to large commercial property casualty accounts.

(2) For purposes of this section, "large commercial property casualty account" means insurance coverage that:

(a) Involves the lines of property and casualty insurance defined in RCW 48.11.040, 48.11.050, 48.11.060, 48.11.070, and/or 48.11.080; and

(b) Is purchased by a business, not-for-profit organization, or public entity with enough insurance buying experience to negotiate with insurers in a largely unregulated environment and that meets any two of the following criteria:

(i) Annual premiums of one hundred thousand dollars or more, excluding workers compensation insurance issued by the department of labor and industries and types of insurance listed in subsection (6) of this section;

(ii) Net revenues or sales in excess of one hundred million dollars;

(iii) More than two hundred employees;

(iv) Net worth over fifty million dollars;

(v) Is a not-for-profit organization or public entity with an annual budget or assets of at least forty-five million dollars;

(vi) Is a municipality with a population over fifty thousand.

(3) Before an insurer issues coverage in reliance on this section, the insurer or its agent shall notify the insured in writing that the rates have not been and will not be filed for the commissioner's approval.

(4) Property rates used on large commercial property casualty accounts will not be audited by the Washington Insurance Examining Bureau under WAC 284-20-006.

(5) The commissioner retains the right and ability to examine the rates used on large commercial property casualty accounts to ascertain whether they meet the requirements of RCW 48.19.020 and other statutes. The insurer shall maintain records supporting the rating and premium determination of each policy issued in reliance on this section. These records

shall be retained by the insurer for a minimum of three years and made available at all reasonable times for the commissioner's examination.

(6) Subsection (1) of this section does not apply to:

(a) Professional liability insurance, including medical malpractice insurance;

(b) Directors' and officers' liability insurance purchased by individuals;

(c) Reimbursement insurance policies that reimburse service contract providers or protection product guarantee providers for contractual obligations assumed under a service contract or protection product guarantee; and

(d) Master policies under which certificates of coverage are issued to individual consumers, households, businesses, or other organizations.

[Statutory Authority: RCW 48.02.060 and 48.19.080. 07-09-085 (Matter No. R 2006-12), § 284-24-120, filed 4/17/07, effective 5/18/07. Statutory Authority: RCW 48.02.060, 48.18.100(6), and 48.19.080. 04-01-175 (Matter No. R 2003-04), § 284-24-120, filed 12/23/03, effective 1/23/04. Statutory Authority: RCW 48.02.060, 48.18.100, 48.19.080. 02-02-068 (Order R 2001-09), § 284-24-120, filed 12/28/01, effective 12/31/01. Statutory Authority: RCW 48.02.060 and 48.19.080. 99-23-068 (Matter No. R 99-5), § 284-24-120, filed 11/15/99, effective 12/16/99.]

Chapter 284-24A WAC

RULES THAT APPLY TO INSURERS THAT USE CREDIT HISTORY FOR PERSONAL INSURANCE UNDERWRITING OR RATING

WAC

284-24A-011 What types of information must an insurer provide in addition to the reason(s) for the adverse action to comply with WAC 284-24A-010(2)?

WAC 284-24A-011 What types of information must an insurer provide in addition to the reason(s) for the adverse action to comply with WAC 284-24A-010(2)? (1) Insurers must provide information that helps the consumer determine why the consumer was charged a higher premium or determined to be ineligible for coverage by the insurer. The following information must be included with the reason for the adverse action:

(a) A description of the attribute of credit history that adversely affected the consumer's insurance score;

(b) How the attribute of credit history affected the insurance score; and

(c) Any actions that are available to the consumer that may improve this attribute of the insurance score.

(2) If an insurer refers to insurance industry research or studies to justify the effect of an insurance score on premiums or eligibility for coverage, the insurer must file those studies with the insurance commissioner so that they are available for public disclosure.

[Statutory Authority: RCW 48.02.060 and 48.18.545. 07-14-103 (Matter No. R 2007-03), § 284-24A-011, filed 7/2/07, effective 8/2/07. Statutory Authority: RCW 48.02.060, 48.18.545, 48.19.035, and 48.30.010. 05-02-026 (Matter No. R 2004-01), § 284-24A-011, filed 12/29/04, effective 7/1/05.]

Chapter 284-24D WAC

MEDICAL MALPRACTICE CLOSED CLAIM DATA REPORTING RULES FOR FACILITIES AND PROVIDERS

WAC

284-24D-010	Purpose.
284-24D-020	Definitions.
284-24D-030	How will the commissioner ensure data confidentiality under RCW 48.140.060(2)?
284-24D-040	How are closed claims reported to the commissioner?
284-24D-050	How will the OIC assign user ID codes to reporting entities?
284-24D-060	What types of claims must be reported to the commissioner?
284-24D-070	Are write-offs or other small sums of money provided as customer service gestures considered claims?
284-24D-080	When is a claim considered closed?
284-24D-090	When are closed claim reports due?
284-24D-100	Can a reporting entity reopen a claim or make changes to previously reported data?
284-24D-110	How should reporting entities assign claim and incident identifiers?
284-24D-120	When is the primary insuring entity responsible for reporting closed claims to the commissioner?
284-24D-130	When is an excess insuring entity responsible for reporting closed claims to the commissioner?
284-24D-140	When is a self-insurer responsible for reporting closed claims to the commissioner?
284-24D-150	May a self-insurer report claims on behalf of itself and an excess insuring entity?
284-24D-160	When is a facility or provider principally responsible for reporting closed medical malpractice claims to the commissioner?
284-24D-170	What does "date of notice" mean?
284-24D-180	How should the type of medical specialty be reported?
284-24D-190	How should the type of health care facility be reported?
284-24D-200	What should be reported as the primary location where the medical malpractice incident occurred?
284-24D-210	How should the incident city be reported?
284-24D-220	How should injury severity be reported using the National Practitioner Data Bank (NPDB) severity scale?
284-24D-230	What should be reported as the reason for the medical malpractice claim?
284-24D-240	How should claim disposition information be reported?
284-24D-250	How should information about the timing of the settlement be reported?
284-24D-260	Are claim payments reported on a gross or net basis?
284-24D-270	What does an insuring entity report when the damages exceed policy limits?
284-24D-280	Are subrogation recoveries subject to reporting?
284-24D-290	How are structured settlements reported?
284-24D-300	If the court itemizes damages, what information must be reported?
284-24D-310	What information must be reported if the court does not itemize damages or a claim is settled by the parties?
284-24D-320	How should "companion claims" be reported?
284-24D-330	How much detail is required when reporting allocated loss adjustment expenses?
284-24D-340	If defense services are provided by company employees, must company overhead be reported with ALAE?
284-24D-350	How are economic damages allocated under RCW 48.140.030 (1)(b)(iii)?
284-24D-360	What elements of economic loss must a reporting entity include when reporting economic damages?
284-24D-362	What process must a person use to estimate economic damages?
284-24D-364	What sources of information can a reporting entity use to estimate economic damages?
284-24D-366	Will the OIC provide guidelines or tools which reporting entities can use when estimating economic damages?
284-24D-370	How are paid and estimated economic damages reported under RCW 48.140.040 (1)(b)(iii)?

WAC 284-24D-010 Purpose. This chapter contains procedural rules to implement chapter 48.140 RCW. This chapter describes the rules, practices and procedures that insuring entities, self-insurers, health care facilities and pro-

viders must use to report data to the commissioner as required by chapter 48.140 RCW.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-010, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-020 Definitions. The definitions in this section apply throughout this chapter.

(1) "Allocated loss adjustment expense" or "ALAE" means defense and cost containment expenses paid or incurred for defense, litigation and medical cost containment expenses and services. Either internal staff, such as in-house counsel or professional medical staff, or external staff, such as defense counsel or expert witnesses, may provide defense and cost containment services.

(a) Defense and cost containment expenses and services include:

(i) Defense services provided by:

(A) Attorneys or expert witnesses; and

(B) Private investigators, hearing representatives or fraud investigators.

(ii) Cost containment activities and services performed by external or internal experts to defend the claim, including:

(A) Case evaluation, such as evaluating whether the medical care provided met professional standards;

(B) Risk assessment;

(C) Case preparation and management;

(D) Medical record review; and

(E) Settlement negotiations.

(iii) Specific case-related expenses, such as:

(A) Surveillance expenses;

(B) Court costs;

(C) Medical examination fees;

(D) The costs of laboratory, X-ray and other medical tests;

(E) Autopsy expenses;

(F) Stenographic expenses;

(G) Fees associated with witnesses and summonses; and

(H) The costs to obtain copies of documents.

(b) Allocated loss adjustment expenses do not include:

(i) Expenses incurred to determine whether coverage is available; or

(ii) Expenses or costs associated with external or internal claims adjusting staff.

(2) "Claim" means the same as in RCW 48.140.010(1).

(3) "Claim identifier" means the unique number assigned to a claim by the reporting entity as required by RCW 48.140.030 (1)(a).

(4) "Claimant" means the same as in RCW 48.140.-010(2).

(5) "Closed claim" means the same as in RCW 48.140.-010(3).

(6) "Commissioner" means the insurance commissioner.

(7) "Companion claims" means the same as in RCW 48.140.030 (1)(b).

(8) "Economic damages" means the same as in RCW 4.56.250 (1)(a).

(9) "Excess insuring entity" means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.

(10) "Facility" means the same as in RCW 48.140.010 (6).

(11) "Paid and estimated economic damages" means economic damages paid to a claimant based on:

- (a) Objectively verifiable evidence; and
- (b) Estimates developed from the injured person's available personal data and related economic data. Estimated economic damages typically include, but are not limited to:
 - (i) Lost earnings and benefits;
 - (ii) Lost earnings potential;
 - (iii) Lost value of household services; and
 - (iv) Future medical care costs.

(12) "Incident identifier" means the unique number assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of actual or alleged medical malpractice.

(13) "Insuring entity" means the same as in RCW 48.140.010(8).

(14) "Medical malpractice" means the same as in RCW 48.140.010(9).

(15) "OIC" means office of insurance commissioner.

(16) "Primary insuring entity" means the insuring entity that originates the primary layer of insurance coverage.

(17) "Provider" means the same as in RCW 48.140.010(7).

(18) "Record identifier" means a number assigned to a claim by the reporting site when a reporting entity first enters closed claim data.

(19) "Reporting entity" means any person or entity required to report data under RCW 48.140.020.

(20) "Reporting site" means the OIC web-based application that insuring entities, facilities, providers, and self-insurers must use to report medical malpractice closed claim data.

(21) "Self-insurer" means the same as in RCW 48.140.010(11).

(22) "User ID" is a permanent number assigned by the reporting site to each insuring entity, self-insurer, facility or provider.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-020, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under chapter 48.140 RCW from public disclosure. To ensure data confidentiality, the commissioner will:

- (1) Develop a secure web-based data reporting application;
- (2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;
- (3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;
- (4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;
- (5) Develop procedures to use if data are accidentally released; and
- (6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-030, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-040 How are closed claims reported to the commissioner? (1) Except as provided in subsection (2) of this section, reporting entities must use the reporting site maintained by the OIC to report closed claims. To help reporting entities collect data, the commissioner will post reporting forms on the OIC internet site so that reporting entities can organize data before entering data into the reporting site.

(2) The commissioner may permit a reporting entity to transmit data electronically in an alternative format if the reporting entity develops, at its own expense, an interface that is compatible with the OIC closed claim data base.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-040, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-050 How will the OIC assign user ID codes to reporting entities? The reporting site will assign a permanent user ID to each reporting entity the first time it enters a closed claim into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-050, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-060 What types of claims must be reported to the commissioner? The types of closed medical malpractice claims that must be reported to the OIC include:

- (1) Claims closed with an indemnity payment;
- (2) Claims closed with paid allocated loss adjustment expenses; and
- (3) Claims closed with both indemnity payments and allocated loss adjustment expenses.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-060, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Reporting entities are not required to report these types of accommodations to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-070, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-080 When is a claim considered closed? A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:

- (1) Issues the final payment to the claimant in the form of a check or draft;
- (2) Pays all outstanding bills for allocated loss adjustment expenses; and
- (3) If applicable, receives all indemnity and allocated loss adjustment expense claim payment data needed for reporting under this chapter from a facility, provider or excess insuring entity.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-080, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-090 When are closed claim reports due? Under RCW 48.140.020, reporting entities must report

all claims closed in the preceding calendar year to the commissioner.

(1) Beginning in 2009, closed claim reports for the prior calendar year are due by March 1.

(2) A reporting entity may report a closed claim any time after the claim is closed, but no later than March 1.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-090, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-100 Can a reporting entity reopen a claim or make changes to previously reported data? The reporting site will allow the reporting entity to change previously reported closed claim data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow a reporting entity to change previously reported data.

(a) The reporting entity can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

(b) Changes and corrections submitted by reporting entities after June 30 of each year will appear in future reports and statistical summaries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-100, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-110 How should reporting entities assign claim and incident identifiers? (1) Consistent with requirements of RCW 48.140.030(1), the reporting entity must assign a different claim identification number to each closed claim report.

(a) The claim identifier must consist solely of numbers. When the reporting entity enters a claim into the reporting site, the site will automatically combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.

(b) The OIC will use the record identifier to trace the claim for auditing purposes.

(2) If a claimant makes claims against more than one facility or provider, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

(a) The incident identifier for companion claims must consist solely of numbers.

(b) The insuring entity or self-insurer is responsible to report claims only if it provides insurance coverage for a facility or provider and defends the claim.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-110, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-120 When is the primary insuring entity responsible for reporting closed claims to the commissioner? Primary insuring entities are principally responsible for reporting closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

(1) The primary insuring entity must report the total amounts paid to settle the claim, including any claim payments or ALAE payments made by:

(a) A facility or provider;

(b) An excess insuring entity; or

(c) Any other person or entity on behalf of the provider.

(2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.

(3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:

(a) The primary insuring entity must report all paid indemnity and allocated loss adjustment expense; and

(b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-120, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-130 When is an excess insuring entity responsible for reporting closed claims to the commissioner? (1) If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs allocated loss adjustment expenses, the excess insuring entity is principally responsible to report closed claim data required under chapter 48.140 RCW and this chapter.

(a) Self-insurers must report all claim payments and allocated loss adjustment expenses to the excess insuring entity for reporting purposes; and

(b) The excess insuring entity must report data on behalf of itself and the self-insurer.

(2) An excess insurer is not responsible to report closed claim data reported by a primary insuring entity under WAC 284-24D-120.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-130, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-140 When is a self-insurer responsible for reporting closed claims to the commissioner? If a closed claim payment falls within its self-insured retention, the self-insurer must report closed claim data required under chapter 48.140 RCW and this chapter to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-140, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-150 May a self-insurer report claims on behalf of itself and an excess insuring entity? A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insurer. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:

(1) Notify the commissioner in writing of this arrangement;

(2) Report closed claim data required under chapter 48.140 RCW and this chapter on behalf of itself and the excess insuring entity; and

(3) Accept responsibility for compliance with RCW 48.140.020(2).

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-150, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-160 When is a facility or provider principally responsible for reporting closed medical malpractice claims to the commissioner? Under RCW 48.140.020(1), a facility or provider must report closed claims if the facility or provider:

(1)(a) Makes indemnity payments directly to the claimant or incurs ALAE expenses to defend the claim, or both; and

(b) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay for the claim; or

(2) Is insured by a risk retention group and the risk retention group refuses to report closed claim data and asserts that the federal Liability Risk Retention Act (95 Stat. 949; 15 U.S.C. 3901 net seq.) preempts state law; or

(3) Is insured by an unauthorized insurer and the unauthorized insurer refuses to report closed claim data and asserts a federal exemption or other jurisdictional preemption.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-160, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-170 What does "date of notice" mean? RCW 48.140.030 (8)(b) says that reporting entities must report the date that the insuring entity, self-insurer, facility or provider is presented with the claim. For reporting purposes, the "date of notice" is the date on which the:

(1) Insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

(2) Claimant notifies the facility or provider of a claim if insurance coverage is not available.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-170, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-180 How should the type of medical specialty be reported? When reporting medical specialties as required under RCW 48.140.030(2), reporting entities must use the *Specialty Codes* published by the National Practitioner Data Bank (NPDB).

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-180, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-190 How should the type of health care facility be reported? When reporting the type of health care facility under RCW 48.140.030(3), the reporting entity must use the *Type of Organization Codes* published by the NPDB. Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-190, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-200 What should be reported as the primary location where the medical malpractice incident occurred? When reporting the location within a facility where the incident occurred under RCW 48.140.030(4), the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:

- (1) Catheterization lab;
- (2) Critical care unit;
- (3) Dispensary;
- (4) Emergency department;
- (5) Labor and delivery room;
- (6) Laboratory;
- (7) Nursery;
- (8) Operating room;
- (9) Outpatient department;
- (10) Patient room;
- (11) Pharmacy;
- (12) Physical therapy department;
- (13) Radiation therapy department;
- (14) Radiology department;
- (15) Recovery room;
- (16) Rehabilitation center;
- (17) Special procedure room;
- (18) Location other than an inpatient facility:
- (a) Clinical support center, such a laboratory or radiology center;
- (b) Office;
- (c) Walk-in clinic; or
- (d) Other;
- (19) Other department in hospital;
- (20) Unknown; and
- (21) Other.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-200, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-210 How should the incident city be reported? When reporting the incident city under RCW 48.140.030(5), the reporting entity must report the incident city based on the location of the facility where the incident occurred. If more than one incident led to the claim, the reporting entity must choose the location where the incident occurred that most directly caused the injury.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24D-210, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-220 How should injury severity be reported using the National Practitioner Data Bank (NPDB) severity scale? When reporting the severity of an injury under RCW 48.140.030(7), the reporting entity must report using the NPDB severity scale. This scale shows the medical outcome for temporary and permanent injuries, and is included below.

- (1) Temporary injuries include:
 - (a) Emotional injury only, such as fright, where no physical damage occurred;
 - (b) Insignificant injury such as lacerations, contusions, minor scars or rash where no delay in recovery occurs;
 - (c) Minor injury such as infection, fracture set improperly, or a fall in the hospital, where recovery is complete but delayed; or
 - (d) Major injury such as burns, surgical material left, drug side effect, brain damage, where recovery is complete but delayed.
- (2) Permanent injuries include:
 - (a) Minor injury such as loss of fingers, loss or damage to organs, where the injury is not disabling;

(b) Significant injury such as deafness, loss of limb, loss of eye, loss of one kidney or lung;

(c) Major injury such as paraplegia, blindness, loss of two limbs, brain damage;

(d) Grave injury such as quadriplegia, severe brain damage, life long care or fatal prognosis; or

(e) Death.

(3) The reporting entity should report the principal injury if several injuries are involved.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-220, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-230 What should be reported as the reason for the medical malpractice claim? When reporting the reason for a medical malpractice claim under RCW 48.140.030(11), the reporting entity must use the same *Allegation Group and Specific Allegation Codes* published by the National Practitioner Data Bank.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-230, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-240 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 48.140.030(9), reporting entities must describe the method of claim disposition using one of the descriptions listed below:

(1) Claim abandoned by claimant.

(2) Claim settled by the parties.

(3) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for plaintiff;

(b) Directed verdict for defendant;

(c) Judgment notwithstanding verdict for plaintiff (judgment for defendant);

(d) Judgment notwithstanding verdict for defendant (judgment for plaintiff);

(e) Involuntary dismissal;

(f) Judgment for plaintiff;

(g) Judgment for defendant;

(h) Judgment for plaintiff after appeal; or

(i) Judgment for defendant after appeal.

(4) Claim settled by alternative dispute resolution process, whether resolved by:

(a) Arbitration award for plaintiff;

(b) Arbitration for defense;

(c) Mediation;

(d) Private trial; or

(e) Other type of alternative dispute resolution process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-240, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-250 How should information about the timing of the settlement be reported? When reporting the timing of the settlement under RCW 48.140.030(9), reporting entities must report whether the claim is settled:

(1) Before filing suit, requesting arbitration or mediation hearing;

(2) Before trial, arbitration or mediation;

(3) During trial, arbitration or mediation;

(4) After trial or hearing, but before judgment or award;

(5) After judgment or decision, but before appeal;

(6) During an appeal; or

(7) After an appeal.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-250, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-260 Are claim payments reported on a gross or net basis? Reporting entities must report claim payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:

(1) Reimbursement for a deductible by the insured;

(2) Reimbursement for claim payments by a reinsurer; or

(3) Anticipated subrogation recoveries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-260, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-270 What does an insuring entity report when the damages exceed policy limits? When damages exceed the policy limits, the insuring entity must report the total amount it paid on behalf of its insured. The reporting entity must report:

(1) The actual claim payment, which may be either:

(a) The policy limit; or

(b) The actual amount paid on behalf of the insured. The actual amount paid by the insuring entity may be either higher or lower than the policy limit, depending on the settlement agreement.

(2) Additional payments made to the claimant by an insured facility or provider; and

(3) Allocated loss adjustment expenses paid by both the insuring entity and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-270, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-280 Are subrogation recoveries subject to reporting? Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any ALAE incurred to obtain those proceeds. If necessary, the insuring entity may reopen the claim under WAC 284-24D-100.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-280, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-290 How are structured settlements reported? (1) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.

(2) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-290, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-300 If the court itemizes damages, what information must be reported? If the court itemizes damages, the reporting entity must report these itemized damages:

- (1) The total amount of the verdict, judgment, or settlement;
- (2) The gross amount paid to indemnify the claimant;
- (3) Itemized economic and noneconomic damages as allocated by the court; and
- (4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-300, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-310 What information must be reported if the court does not itemize damages or a claim is settled by the parties? When reporting claims under RCW 48.140.030 (10)(b), the reporting entity must report losses on a gross basis, including:

- (1) The total amount of the verdict, judgment, or settlement;
- (2) The gross amount paid to indemnify the claimant;
- (3) Paid and estimated economic damages; and
- (4) Allocated loss adjustment expenses paid by the insuring entities and the insured.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-310, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-320 How should "companion claims" be reported? If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claims in this manner:

- (1) If a claimant makes a claim against more than one facility or provider, the reporting entity must assign the same incident identifier to each "companion claim."

- (2) The reporting entity must maintain all data required under chapter 48.140 RCW and this chapter for each facility or provider it defends.

- (3) Indemnity payments and allocated loss adjustment expenses paid to defend and settle each claim must be reported separately for each facility or provider. The reporting entity must allocate:

- (a) Indemnity payments between defendants based on an assessment of comparative fault; and
- (b) ALAE payments between defendants based on which defendant benefited from the defense services.

- (4) If the reporting entity makes payments in the absence of clear legal liability, it may allocate claim or ALAE payments equally among all defendants.

- (5) Under this section, the reporting entity is responsible for reporting incident level data only for its own claims.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-320, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-330 How much detail is required when reporting allocated loss adjustment expenses? When reporting allocated loss adjustment expenses under RCW 48.140.030 (10)(a)(v) or (b)(iv), the reporting entity must report:

- (1) ALAE for defense counsel, including both in-house and outside counsel;
- (2) ALAE for expert witnesses, including both in-house and outside experts;
- (3) All other ALAE; and

- (4) Total ALAE.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-330, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-340 If defense services are provided by company employees, must company overhead be reported with ALAE? (1) Some insuring entities and self-insurers use the services of internal staff to defend claims. For example, an insuring entity or self-insurer may:

- (a) Ask its professional medical staff to:
 - (i) Evaluate medical care;
 - (ii) Review medical records; or
 - (iii) Assist in case preparation.
- (b) Retain in-house legal counsel to:
 - (i) Assess risk of litigation;
 - (ii) Evaluate legal issues;
 - (iii) Engage in case preparation or management activities, or settlement negotiations.

- (2) When calculating ALAE, a reporting entity that uses internal staff to defend a claim as described in subsection (1) of this section and WAC 284-24D-020(1):

- (a) Must include salary, benefits and an allocation for overhead for those employees; and
- (b) May use average salaries and time studies when calculating ALAE.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-340, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-350 How are economic damages allocated under RCW 48.140.030 (10)(b)(iii)? If the reporting entity makes indemnity payments to a claimant, the reporting entity must allocate economic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not allocate using a fixed formula, such as fifty percent of total paid indemnity, to economic damages.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-350, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-360 What elements of economic loss must a reporting entity include when reporting economic damages? When reporting paid and estimated economic damages, reporting entities must use reasonable judgment to estimate the following elements of loss:

- (1) Medical expenses;
- (2) Loss of earnings;
- (3) Burial costs;
- (4) Cost of obtaining substitute domestic services;
- (5) Loss of employment; and
- (6) Loss of business or employment opportunities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-360, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-362 What process must a person use to estimate economic damages? If a reporting entity makes indemnity payments to a claimant that include compensation for future economic damages, the person calculating damages must use the principles listed in this section.

- (1) Where appropriate, the person estimating economic damages must:

(a) Project the elements of loss listed in WAC 284-24D-360:

- (i) For the duration of the injury or disability; or
- (ii) In the event of death, for the anticipated life span of the injured person; and
- (b) Discount damages to present value;
- (c) Consider related factors, such as:
 - (i) Issues of negligence and liability;
 - (ii) The relative strength of the defense; and
 - (iii) The component of the claim payment driven by economic damages.

(2) Reporting entities must select reasonable discount factors when estimating economic damages.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-362, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-364 What sources of information can a reporting entity use to estimate economic damages? When estimating economic damages, the person estimating damages may use data from public sources, such as the Bureau of Labor Statistics, to supplement data collected during the claim investigation.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-364, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-366 Will the OIC provide guidelines or tools which reporting entities can use when estimating economic damages? From time to time, the OIC may publish information or suggestions that reporting entities can use when estimating economic damages. Periodically, the OIC will update its internet site to include links to documents or information of interest to reporting entities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-366, filed 6/4/07, effective 7/22/07.]

WAC 284-24D-370 How are paid and estimated economic damages reported under RCW 48.140.040 (10)(b) (iii)? A reporting entity must:

- (1) Combine all elements of paid and estimated economic loss described in WAC 284-24D-360; and
- (2) Report one figure for paid and estimated economic loss to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24D-370, filed 6/4/07, effective 7/22/07.]

Chapter 284-24E WAC

MEDICAL MALPRACTICE CLAIM SETTLEMENT DATA REPORTING RULES FOR ATTORNEYS AND CLAIMANTS

WAC

284-24E-010	Purpose.
284-24E-020	Definitions.
284-24E-030	How will the commissioner ensure data confidentiality under RCW 48.140.060(2)?
284-24E-040	How is claim settlement data reported to the commissioner?
284-24E-050	How will the OIC assign user ID codes?
284-24E-060	What types of settled claims must be reported to the commissioner?
284-24E-063	When is a claim considered settled and subject to reporting with the OIC?
284-24E-070	Are write-offs or other small sums of money provided as customer service gestures considered claims?

284-24E-080	Who has the primary responsibility for reporting claim settlement data to the commissioner?
284-24E-090	When are claim reports due?
284-24E-100	Can settlement reports be reopened to make changes or corrections to previously reported data?
284-24E-110	How should claim disposition information be reported?
284-24E-120	How should information about the timing of the settlement be reported?
284-24E-130	How is the judgment or settlement amount reported?
284-24E-140	How are structured settlements reported?
284-24E-150	How should claims settlement data be reported if there is more than one defendant?

WAC 284-24E-010 Purpose. This chapter contains procedural rules to implement RCW 7.70.140. This chapter describes the rules, practices and procedures that claimants and their attorneys must use to report claim settlement data to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-010, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-020 Definitions. The definitions in this section apply throughout this chapter.

- (1) "Claim" means the same as in RCW 48.140.010(1).
- (2) "Claimant" means the same as in RCW 48.140.010(2), and, for reporting purposes, includes a claimant's legal representative.
- (3) "Commissioner" means the insurance commissioner.
- (4) "Facility" means the same as in RCW 48.140.010(6).
- (5) "Insuring entity" means the same as in RCW 48.140.010(8).
- (6) "Medical malpractice" means the same as in RCW 48.140.010(9).
- (7) "OIC" means office of insurance commissioner.
- (8) "Provider" means the same as in RCW 48.140.010(7).
- (9) "Record identifier" means the number assigned to a claim by the reporting site when a person first enters claim settlement information.
- (10) "Reporting site" means the OIC web-based application that attorneys and claimants must use to report medical malpractice claim settlement data.
- (11) "Self-insurer" means the same as in RCW 48.140.010(11).
- (12) "User ID" is a permanent number assigned by the reporting site to any claimant or attorney who reports claim settlement data.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-020, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-030 How will the commissioner ensure data confidentiality under RCW 48.140.060(2)? RCW 42.56.400(11) protects data filed under RCW 7.70.140 from public disclosure. To ensure data confidentiality, the commissioner will:

- (1) Develop a secure web-based data reporting application;
- (2) Train OIC staff on applicable laws and agency practices related to protecting confidential and privileged information;
- (3) Limit access to the claim data base to OIC staff responsible for preparing the statistical summaries and annual report;

(4) Develop and implement confidentiality procedures to be used by staff that has access to the closed claim data base;

(5) Develop procedures to use if data are accidentally released; and

(6) Use aggregate data in summaries and reports so that individual claim data cannot be identified.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-030, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-040 How is claim settlement data reported to the commissioner? Persons reporting claim settlement data must use the reporting site maintained by the commissioner. To help attorneys and claimants collect data, the commissioner will post a reporting form on the OIC internet site so that claim settlement data can be organized before it is entered into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-040, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-050 How will the OIC assign user ID codes? The reporting site will assign a permanent user ID to an attorney or claimant the first time the attorney or claimant enters claim settlement data into the reporting site.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-050, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-060 What types of settled claims must be reported to the commissioner? If a medical malpractice claim is actionable under chapter 7.70 RCW and the claimant receives an indemnity payment from an insuring entity, self-insurer, facility or provider, the claimant or his or her attorney must report claim settlement data to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-060, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-063 When is a claim considered settled and subject to reporting with the OIC? A claim is settled when the claimant:

- (1) Receives final indemnity payment(s) from all defendants;
- (2) Pays all related legal expenses; and
- (3) Pays all related attorney fees agreed to by the claimant and his or her attorney.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-063, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-070 Are write-offs or other small sums of money provided as customer service gestures considered claims? If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under RCW 48.140.010(1). Claimants are not required to report these types of accommodations to the commissioner.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-070, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-080 Who has the primary responsibility for reporting claim settlement data to the commissioner? (1) If a claimant is represented by an attorney, the

attorney must report claim settlement data to the commissioner after the claim is settled.

(2) If a claimant is not represented by an attorney:

(a) The claimant must report claim settlement data to the commissioner; and

(b) An insuring entity, self-insurer or provider may assist or inform the claimant of his or her reporting responsibilities.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-080, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-090 When are claim reports due?

Under RCW 7.70.140, a claimant or his or her attorney must report claims settled in the preceding calendar year to the commissioner.

(1) Beginning in 2009, claim settlement reports for the prior calendar year are due by March 1.

(2) An attorney or claimant may enter data into the reporting site at any time after the claim is settled, but no later than March 1.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-090, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-100 Can settlement reports be reopened to make changes or corrections to previously reported data? The reporting site will allow an attorney or claimant to change previously reported claim settlement data, subject to these rules:

(1) OIC will freeze data contained in the reporting site from March 15 through June 30 each year so the OIC can prepare reports and statistical summaries can be prepared as required by RCW 48.140.040 and 48.140.050. The commissioner may accept changes to previously reported data if a correction or omission will significantly affect the conclusions stated in the annual report.

(2) After June 30, the reporting site will allow an attorney or claimant to change previously reported data.

(a) An attorney or claimant can reopen a claim report using their permanent user ID and the record identifier and make changes or corrections to data.

(b) Changes and corrections submitted after June 30 of each year will appear in future reports and statistical summaries.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140.07-12-057 (Matter No. R 2006-02), § 284-24E-100, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-110 How should claim disposition information be reported? When reporting the final method of claim disposition under RCW 7.70.140 (2)(b)(v), an attorney or claimant must describe the method of claim disposition using one of the descriptions listed below:

(1) Claim is settled by the parties.

(2) Claim is disposed of by a court when the court issues a:

(a) Directed verdict for plaintiff;

(b) Judgment notwithstanding verdict for defendant (judgment for plaintiff);

(c) Judgment for plaintiff; or

(d) Judgment for plaintiff after appeal.

(3) Claim settled by alternative dispute resolution process, whether resolved by:

- (a) Arbitration;
- (b) Mediation;
- (c) Private trial; or
- (d) Other type of alternative dispute resolution process.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-110, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-120 How should information about the timing of the settlement be reported? Persons reporting claims must report whether the claim is settled:

- (1) Before filing suit, requesting arbitration or mediation hearing;
- (2) Before trial, arbitration or mediation;
- (3) During trial, arbitration or mediation;
- (4) After trial or hearing, but before judgment or award;
- (5) After judgment or decision, but before appeal;
- (6) During an appeal; or
- (7) After an appeal.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-120, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-130 How is the judgment or settlement amount reported? Persons reporting claims must report the total amount paid by all defendants to the claimant to settle the claim.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-130, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-140 How are structured settlements reported? (1) If a claim is settled with a structured settlement agreement, the attorney or claimant must report the lump-sum payment that is paid for the annuity.

(2) If a claim is settled with a combination of a lump-sum payment to the claimant and a structured settlement, the attorney or claimant must report the sum of both payments.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-140, filed 6/4/07, effective 7/22/07.]

WAC 284-24E-150 How should claims settlement data be reported if there is more than one defendant? An attorney or claimant must wait until all claims are settled before reporting under RCW 7.70.140. After all claims are settled, the person reporting claim settlement data must report these data to the commissioner:

- (1) The total of all settlements paid by all defendants; and
- (2) The total amounts paid by the claimant for legal expenses, itemized by:
 - (a) Court costs;
 - (b) Expert witnesses fees; and
 - (c) Attorney fees and expenses.

[Statutory Authority: RCW 48.02.060, 48.140.060, and 7.70.140. 07-12-057 (Matter No. R 2006-02), § 284-24E-150, filed 6/4/07, effective 7/22/07.]

Chapter 284-30 WAC TRADE PRACTICES

WAC

284-30-500	Unfair practices with respect to vehicle insurance.
284-30-850	Authority, purpose, and effective date.
284-30-855	Scope.

284-30-860	Exemptions.
284-30-865	Definitions.
284-30-870	Practices declared to be unfair or deceptive when committed on a military installation.
284-30-872	Practices declared to be unfair or deceptive regardless of where they occur.

WAC 284-30-500 Unfair practices with respect to vehicle insurance. (1) The following practices by any insurer with respect to every vehicle liability insurance policy applicable to private passenger automobiles registered or principally garaged in this state are unfair and prohibited:

(a) Failing to provide, to any insured under such policy, liability limits at least as great as those required by RCW 46.29.090, as measured at the effective date of the applicable policy or its renewal;

(b) Denying or limiting liability coverage in such policy to less than the limits required by RCW 46.29.090, solely because the injured person is related to the insured by blood or marriage, as, for example, through use of so-called "family" or "household" exclusions;

(c) Denying or limiting liability coverage in such policy, with respect to injuries sustained by motorcycle passengers, to an amount below the bodily injury liability limits required by RCW 46.29.090, if the policy provides liability coverage for an insured's ownership, operation, or use of a motorcycle.

(2) With respect to vehicle insurance policies applicable to private passenger vehicles registered or principally garaged in this state, failing to provide a named insured an itemization of the premium costs for the coverages under the policy if there are identifiable separate premium charges for the coverages is unfair and prohibited. The required itemization must be given to a named insured no later than at the time of delivery of a policy and must accompany each offer to renew thereafter.

(3) It is an unfair practice for any insurer to consider traffic violations or accidents which occurred more than three years in the past, with respect to the acceptance, rejection, cancellation or nonrenewal of any insured under a private passenger automobile insurance policy, unless, because of the individual's violations, accidents or driving record during the three years immediately past, the earlier violations or accidents are significantly relevant to the individual's qualifications for insurance.

(4) For purposes of this section, the definition of a "private passenger automobile" is that set forth in RCW 48.18.-297, and includes a motorcycle except as otherwise specifically provided in this section.

[Statutory Authority: RCW 48.02.060. 07-19-106 (Matter No. R 2007-07), § 284-30-500, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-500, filed 4/21/87. Statutory Authority: RCW 48.02.060 (3)(a). 85-02-019 (Order R 84-8), § 284-30-500, filed 12/27/84.]

WAC 284-30-850 Authority, purpose, and effective date. In order to prevent unfair methods of insurance sales to active duty service members of the United States armed forces, unfair competition, and unfair or deceptive acts or practices by insurers, fraternal benefit societies, agents, brokers or solicitors, WAC 284-30-850 through 284-30-872 are adopted. These rules may be called the "military sales practices" rules.

(1) The Military Personnel Financial Services Protection Act (P.L. 109-290) was enacted by the 109th Congress to protect members of the United States armed forces from unscrupulous practices regarding the sale of insurance, financial, and investment products on and off military installations. The act requires this state to adopt rules that meet sales practice standards adopted by the National Association of Insurance Commissioners to protect members of the United States armed forces from dishonest and predatory insurance sales practices both on and off of a military installation.

(2) Based on the commissioner's authority under RCW 48.30.010 to define by rule methods of competition and other acts and practices in the conduct of the business of insurance found by the commissioner to be unfair or deceptive, after evaluation of the acts and practices of insurers, fraternal benefit societies, agents, brokers, or solicitors that informed the need for P.L. 109-290, and because the commissioner is required by that act to adopt rules that meet the sales practice standards adopted by the National Association of Insurance Commissioners and federal law, the commissioner finds the acts or practices set forth in WAC 284-30-850 through 284-30-872 to be unfair or deceptive methods of competition or unfair or deceptive acts or practices in the business of insurance.

(3) These military sales practices rules are effective for all benefit contracts, insurance policies and certificates solicited, issued, or delivered in this state on and after (the effective date of these rules).

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-850, filed 8/20/07, effective 9/20/07.]

WAC 284-30-855 Scope. WAC 284-30-850 through 284-30-872 affect all life insurance policies and certificates solicited or sold to an active duty service member of the United States armed forces or his or her dependent.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-855, filed 8/20/07, effective 9/20/07.]

WAC 284-30-860 Exemptions. (1) The following life insurance solicitations or sales are exempt from the requirements of WAC 284-30-850 through 284-30-872:

(a) Credit life insurance.

(b) Group life insurance where there is no in-person face-to-face solicitation of individuals by a licensed agent, broker, or solicitor or where the policy or certificate does not include a side fund.

(c) An application to the insurer that issued the existing policy or certificate when a contractual change or a conversion privilege is being exercised; or when the existing insurance policy or certificate is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term life conversion privilege is exercised among corporate affiliates.

(d) Individual, stand-alone policies of health or disability income insurance.

(e) Contracts offered by Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI), as authorized by 38 U.S.C. section 1965 et seq., and contracts offered by State Sponsored Life Insurance (SSLI) as authorized by 37 U.S.C. Section 707 et seq.

(f) Life insurance policies or certificates offered through or by a nonprofit military association, qualifying under section 501(c)(23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer.

(g) Contracts used to fund any of the following:

(i) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(ii) A plan described by sections 401(a), 401(k), 403(b), 408(k), or 408(p) of the IRC, as amended, if established or maintained by an employer;

(iii) A government or church plan defined in section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under section 457 of the IRC;

(iv) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(v) Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(vi) Prearranged funeral contracts.

(2) Nothing in WAC 284-30-850 through 284-30-872 shall be construed to restrict the ability of nonprofit organizations or other organizations to educate members of the United States armed forces in accordance with federal Department of Defense Instruction 1344.07 "Personal Commercial Solicitation on DOD Installations," or any successor directive.

(3)(a) For purposes of the military sales practices rules, general advertisements, direct mail and internet marketing do not constitute "solicitation." Telephone marketing does not constitute "solicitation" only if the caller explicitly and conspicuously discloses that the product being solicited is life insurance and the caller makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.

(b) Nothing in this section shall be construed to exempt an insurer, agent, broker, or solicitor from the military sales practices rules in any in-person face-to-face meeting established as a result of the solicitation exemptions listed in this section.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-860, filed 8/20/07, effective 9/20/07.]

WAC 284-30-865 Definitions. The following definitions apply to the military sales practices rules, unless the context clearly requires otherwise:

(1) "Active duty" means full-time duty in the active military service of the United States and includes members of the reserve component, such as national guard or reserve, while serving under published orders for active duty or full-time training. This term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of fewer than thirty-one calendar days.

(2) "Department of Defense (DOD) personnel" means all active duty service members and all civilian employees, including nonappropriated fund employees and special government employees, of the Department of Defense.

(3) "Door-to-door" means a solicitation or sales method whereby an agent, broker, or solicitor proceeds randomly or

selectively from household to household without a prior specific appointment.

(4) "General advertisement" means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance or the promotion of an insurer, agent, broker, or solicitor.

(5) "Insurer" means an insurance company, as defined in RCW 48.01.050, that provides life insurance products for sale in this state. The term "insurer" also includes fraternal benefit societies, as defined at RCW 48.36A.010. Whenever the term "insurer," "policy," or "certificate" is used in these military sales practices rules, it includes insurers and fraternal benefit societies and applies to all insurance policies, benefit contracts, and certificates of life insurance issued by them.

(6) "Known" or "knowingly" means, depending on its use in WAC 284-30-870 and 284-30-872, that the insurer or agent, broker, or solicitor had actual awareness, or in the exercise of ordinary care should have known at the time of the act or practice complained of that the person being solicited is either:

(a) A service member; or

(b) A service member with a pay grade of E-4 or below.

(7) "Life insurance" has the meaning set forth in RCW 48.11.020.

(8) "Military installation" means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

(9) "MyPay" means the Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certain discretionary pay transactions or provide updates to personal information data elements without using paper forms.

(10) "Service member" means any active duty officer (commissioned and warrant) or any enlisted member of the United States armed forces.

(11) "Side fund" means a fund or reserve that is part of or is attached to a life insurance policy or certificate (except for individually issued annuities) by rider, endorsement, or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

(a) Accumulated or cash value or secondary guarantees provided by a universal life policy;

(b) Cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

(c) A premium deposit fund which:

(i) Contains only premiums paid in advance which accumulate at interest;

(ii) Imposes no penalty for withdrawal;

(iii) Does not permit funding beyond future required premiums;

(iv) Is not marketed or intended as an investment; and

(v) Does not carry a commission, either paid or calculated.

(12) "Specific appointment" means a prearranged appointment that has been agreed upon by both parties and is definite as to place and time.

(13) "United States armed forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-865, filed 8/20/07, effective 9/20/07.]

WAC 284-30-870 Practices declared to be unfair or deceptive when committed on a military installation. (1)

The following acts or practices by an insurer, agent, broker, or solicitor are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance when committed on a military installation and solicited in-person face-to-face:

(a) Knowingly soliciting the purchase of any life insurance policy or certificate door to door or without first establishing a specific appointment for each meeting with the prospective purchaser.

(b) Soliciting service members in a group or mass audience or in a captive audience where attendance is not voluntary.

(c) Knowingly making appointments with or soliciting service members during their normally scheduled duty hours.

(d) Making appointments with or soliciting service members in barracks, day rooms, unit areas, or transient personnel housing, or other areas where the installation commander has prohibited solicitation.

(e) Soliciting the sale of life insurance without first obtaining permission from the installation commander or the commander's designee.

(f) Posting unauthorized bulletins, notices, or advertisements.

(g) Failing to present DD Form 2885 Personal Commercial Solicitation Evaluation, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

(h) Knowingly accepting an application for life insurance or issuing a policy or certificate of life insurance on the life of an enlisted member of the United States armed forces without first obtaining for the insurer's files a completed copy of any required form which confirms that the applicant has received counseling or fulfilled any other similar requirement related to the sale of life insurance established by regulations, directives, or rules of the DOD or any branch of the United States armed forces.

(2) The following acts or practices by an insurer, agent, broker, or solicitor are found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance or improper influences or inducements when committed on a military installation:

(a) Using DOD personnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

(b) Using an agent, broker, or solicitor to participate in any education or orientation program sponsored by United States armed forces.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-870, filed 8/20/07, effective 9/20/07.]

WAC 284-30-872 Practices declared to be unfair or deceptive regardless of where they occur. (1) The following acts or practices by an insurer, agent, broker, or solicitor

are found by the commissioner and declared to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance or improper influences or inducements regardless of the location where they occur:

(a) Submitting, processing, or assisting in the submission or processing of any allotment form or similar device used by the United States armed forces to direct a service member's pay to a third party for the purchase of life insurance. For example, the using or assisting in the use of a service member's "MyPay" account or other similar internet or electronic medium to pay for life insurance is prohibited. For purposes of these military sales practices rules, assisting a service member by providing insurer or premium information necessary to complete any allotment form is not an unfair, deceptive, or prohibited practice.

(b) Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, a formal banking relationship is established when the depository institution:

(i) Provides the service member a deposit agreement and periodic statements and makes the disclosures required by the Truth in Savings Act, 12 U.S.C. § 4301 et seq. and regulations promulgated thereunder; and

(ii) Permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

(c) Employing any device or method, or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance premiums are identified on the service member's leave and earnings statement (or equivalent or successor form) as "savings" or "checking" and where the service member has no formal banking relationship.

(d) Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

(e) Using DOD personnel, directly or indirectly, as a representative or agent in any official or unofficial capacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to their family members.

(f) Offering or giving anything of value, directly or indirectly, to DOD personnel to procure their assistance in encouraging, assisting, or facilitating the solicitation or sale of life insurance to another service member.

(g) Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

(h) Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or state of legal residence for the sole purpose of increasing disposable income in order to purchase life insurance.

(2) The following acts or practices by an insurer, agent, broker, or solicitor may lead to confusion regarding the source, sponsorship, approval, or affiliation of the insurer or any agent, broker or solicitor. They are each found by the

commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation, or using any device, title, descriptive name, or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, agent, broker, or solicitor, or the policy or certificate offered is affiliated, connected, or associated with, endorsed, sponsored, sanctioned, or recommended by the U.S. government, the United States armed forces, or any state or federal agency or governmental entity.

(i) For example, the use of the following titles, including but not limited to the following is prohibited: Battalion insurance counselor, unit insurance advisor, Servicemen's Group Life Insurance conversion consultant, or veteran's benefits counselor.

(ii) A person is not prohibited from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by an accredited institution of higher learning. Examples include, but are not limited to the following: Chartered life underwriter (CLU), chartered financial consultant (ChFC), certified financial planner (CFP), master of science in financial services (MSFS), or masters of science financial planning (MS).

(b) Soliciting the purchase of any life insurance policy or certificate through the use of or in conjunction with any third-party organization that promotes the welfare of or assists members of the United States armed forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, agent, broker, solicitor, or the insurance policy or certificate is affiliated, connected, or associated with endorsed, sponsored, sanctioned, or recommended by the U.S. government, or the United States armed forces.

(3) The following acts or practices by an insurer, agent, broker, or solicitor lead to confusion regarding premiums, costs, or investment returns. They are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

(b) Misrepresenting the mortality costs of a life insurance policy or certificate (except for individually issued annuities), including stating or implying that the policy or certificate costs nothing or is free.

(4) The following acts or practices by an insurer, agent, broker, or solicitor regarding Servicemembers Group Life Insurance (SGLI) or Veterans Group Life Insurance (VGLI) are each found by the commissioner to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Making any representation regarding the availability, suitability, amount, cost, exclusions, or limitations to coverage provided to service members or dependents by SGLI or VGLI, which is false, misleading, or deceptive.

(b) Making any representation regarding conversion requirements, including the costs of coverage, exclusions, or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading, or deceptive.

(c) Suggesting, recommending, or encouraging a service member to cancel or terminate his or her SGLI policy, or issuing a life insurance policy or certificate which replaces an existing SGLI policy unless the replacement takes effect upon or after separation of the service member from the United States armed forces.

(5) The following acts or practices regarding disclosure by an insurer, agent, broker, or solicitor are declared to be false, misleading, unfair, or deceptive methods of competition or unfair or deceptive acts or practices in the conduct of the business of insurance regardless of the location where the act occurs:

(a) Deploying, using, or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an agent, broker, or solicitor, if that is the case, for the purpose of soliciting the purchase of life insurance.

(b) Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person face-to-face meeting with a prospective purchaser.

(c) Except for individually issued annuities, failing to clearly and conspicuously disclose the fact that the policy or certificate being solicited is life insurance.

(d) Failing to make, at the time of sale or offer to an individual known to be a service member, the written disclosures required by Section 10 of the Military Personnel Financial Services Protection Act (P.L. 109-290), p. 16.

(e) Except for individually issued annuities, when the sale is conducted in-person face-to-face with an individual known to be a service member, failing to provide the applicant at the time of application is taken:

(i) An explanation of any free look period with instructions on how to cancel any policy or certificate issued by the insurer; and

(ii) Either a copy of the application or a written disclosure. The copy of the application or the written disclosure must clearly and concisely set out the type of life insurance, the death benefit applied for, and its expected first year cost. A basic illustration that meets the requirements of this state will be considered a written disclosure.

(6) The following acts or practices by an insurer, agent, broker, or solicitor are each found by the commissioner to be false, misleading, unfair or deceptive methods of competition or unfair or deceptive or acts or practices in the conduct of the business of insurance regardless of the location where they occur:

(a) Except for individually issued annuities, recommending the purchase of any life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurance death benefit, standing alone, is suitable.

(b) Offering for sale or selling a life insurance policy or certificate which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI,

is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

(i) "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate, survivors, or dependents.

(ii) Other military survivor's benefits include, but are not limited to: The death gratuity, funeral reimbursement, transition assistance, survivor and dependents' educational assistance, dependency and indemnity compensation, TRICARE healthcare benefits, survivor housing benefits and allowances, federal income tax forgiveness, and Social Security survivor benefits.

(c) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which includes a side fund:

(i) Unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

(ii) Unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined policy or certificate. For this disclosure, the effective rate of return must consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule must be provided for at least each policy year from year one to year ten and for every fifth policy year thereafter, ending at age one hundred, policy maturity, or final expiration; and

(iii) Which by default diverts or transfers funds accumulated in the side fund to pay, reduce, or offset any premiums due.

(d) Except for individually issued annuities, offering for sale or selling any life insurance policy or certificate which after considering all policy benefits, including but not limited to endowment, return of premium, or persistency, does not comply with standard nonforfeiture law for life insurance.

(e) Selling any life insurance policy or certificate to a person known to be a service member that excludes coverage if the insured's death is related to war, declared or undeclared, or any act related to military service, except for accidental death coverage (for example, double indemnity) which may be excluded.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 07-17-120 (Matter No. R 2007-01), § 284-30-872, filed 8/20/07, effective 9/20/07.]

Chapter 284-37 WAC

MARKET CONDUCT OVERSIGHT PROGRAM

WAC

284-37-010	Definitions.
284-37-020	Procedures manuals.
284-37-030	Access to records.
284-37-040	Market conduct annual statement.
284-37-050	Complaint verification.
284-37-060	Dispute resolution.

WAC 284-37-010 Definitions. The following definitions apply throughout this chapter unless the context requires otherwise:

(1) "Insurer" shall have the same meaning as set forth in chapter 82, section 5(4), Laws of 2007, and specifically includes health care service contractors, health maintenance organizations, fraternal benefit societies, and self-funded multiple employer welfare arrangements.

(2) "Insurance" shall have the same meaning as set forth in RCW 48.01.040, and includes all policies and contracts offered by any insurer, as defined in subsection (1) of this section.

(3) "Complaint" means any written or documented oral communication primarily expressing a grievance, meaning an expression of dissatisfaction.

(4) "NAIC" means the National Association of Insurance Commissioners, and has the same meaning as in RCW 48.02.140.

(5) "Records" means any information from data available to the commissioner, surveys, required reports, information collected by the NAIC and other sources in both public and private sectors, and information from within and outside the insurance industry.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-010, filed 8/1/07, effective 9/1/07.]

WAC 284-37-020 Procedures manuals. To foster nationwide consistency in market conduct oversight, and as authorized by chapter 82, sections 6, 7 and 8, Laws of 2007 the commissioner adopts the following procedures and handbooks published by the NAIC and in effect on July 31, 2007, or as later amended. The applicable version of the procedure or handbook will be the version in effect when the relevant market conduct activity was initiated.

(1) *The NAIC Market Regulation Handbook* for all market conduct oversight activities, as defined at chapter 82, section 5(9), Laws of 2007.

(2) *The NAIC Market Conduct Uniform Examination Procedures* for all market conduct examinations, as defined at chapter 82, section 5(10), Laws of 2007.

(3) *The NAIC Standard Data Request* for all requests to insurers for market data, as defined at chapter 82, section 5(11), Laws of 2007.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-020, filed 8/1/07, effective 9/1/07.]

WAC 284-37-030 Access to records. During the market analysis process, the commissioner may require access to identifiable records in the possession of, or subject to control or access by the insurer. This section sets forth the process that the commissioner will follow when requesting records. Whenever possible and appropriate, the commissioner will make these requests electronically.

(1) The commissioner will contact the insurer in writing listing the records to be provided by the insurer for review.

(a) The list will specify the records required by the market conduct oversight personnel and will set forth the preferred method for transmission of records to the market conduct oversight team.

(b) The request will include the reason for the request and summarize how the records are intended to be used.

(2) All requested records must be provided to the commissioner within fifteen working days after receipt of the request.

(3)(a) If the insurer is not able to produce the requested records within the allotted time, the insurer must contact the commissioner before expiration of the allotted time and propose an alternative due date. The request must provide information about its reason for requesting a later due date.

(b) If the insurer is not able to produce the requested records in the format or manner requested by the market conduct oversight team, the insurer must contact the commissioner before expiration of the allotted time and propose an alternative delivery format.

(4) The commissioner will contact the insurer within five working days after receipt of any request for a later due date or alternative delivery format to discuss the proposed alternatives.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-030, filed 8/1/07, effective 9/1/07.]

WAC 284-37-040 Market conduct annual statement.

(1) Every insurer shall file with the commissioner its market conduct annual statement, as required by chapter 82, section 6, Laws of 2007, in accordance with filing instructions published by the NAIC.

(2) For purposes of this chapter, the market conduct annual statement filing is not complete until it has been received by the commissioner, in either hard copy or electronic form, as designated by the commissioner.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-040, filed 8/1/07, effective 9/1/07.]

WAC 284-37-050 Complaint verification. If a complaint is filed against an insurer, the commissioner will notify the insurer following this process. Whenever possible and appropriate, the commissioner will provide the notices detailed below to the insurer electronically.

(1) Initial notice to the insurer. The commissioner will send an initial notice to the insurer that identifies the name of the insurer against whom the complaint was filed using the insurer's name and NAIC number, and any other available identifying information as provided to the commissioner by the complainant.

(a) If the insurer disagrees with the name of the insurer as identified in the complaint, it must file an objection in writing no later than fifteen working days after the date the commissioner sends the notice to the insurer and attach appropriate supporting information or documentation.

(b) Failure of the insurer to object to the legal name and NAIC number provided in the initial notice of the complaint within the allotted time, will be considered to be the insurer's verification that the proper insurer is identified in the complaint.

(c) No extension of time to respond to the initial notice will be permitted except for good cause shown.

(2) Complaint closure notice. The commissioner will send a copy of the proposed complaint closure notice to the insurer at the time the complaint is closed. The complaint closure notice will identify the codes for both the type of coverage and reason for complaints that will be reported to the NAIC.

(a) If the insurer wishes to object to the coding to be reported to the NAIC, an objection must be filed with the commissioner within fifteen working days after the date that the complaint closure notice is sent to the insurer. The objection must contain a concise description of the nature of the objection to the proposed coding and must include appropriate supporting information or documentation.

(b) Upon receipt of the insurer's objection, the commissioner will take reasonable and necessary steps to prevent reporting of that complaint to the NAIC until the insurer's objection is resolved.

(c) Failure of the insurer to object to the proposed coding set forth in the complaint closure notice will be considered verification that the complaint closure notice uses the correct codes and the notice will be reported to the NAIC.

(3) Opportunity to object to coding to be reported to the NAIC.

(a) Within ten working days after the commissioner receives an objection to proposed coding from the insurer, the commissioner will consider the information or documentation provided by the insurer and will advise the insurer that the original proposed coding has been affirmed or modified.

(b) The final complaint coding will be reported to the NAIC no sooner than five working days after resolution of an objection.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-050, filed 8/1/07, effective 9/1/07.]

WAC 284-37-060 Dispute resolution. As required at chapter 82, section 14(3), Laws of 2007, after the deputy insurance commissioner responsible for market conduct oversight has responded to an insurer's issues, the insurer may request mediation of the issues. The following process governs mediation of insurer market conduct oversight issues.

(1) A request for mediation of the issues must be made within five working days after receipt by the insurer of a final decision on any issue.

(2) The commissioner will maintain a list of approved mediators to mediate disputed issues. All approved mediators will be qualified by training and experience.

(a) The commissioner will publish a copy of the current resume and fee schedule of each panel mediator on the commissioner's web site (www.insurance.wa.gov).

(b) At the start of a market analysis process or the start of a market conduct examination, the insurer must select a mediator and alternate mediator from the approved list.

(c) The party requesting mediation is required to pay the costs of the mediator.

(3) As provided at chapter 82, section 14(4), Laws of 2007, at any point in the mediation, the insurer may commence an adjudicative proceeding under chapters 48.04 and 34.05 RCW.

[Statutory Authority: RCW 48.02.060 and 2007 c 82. 07-16-146 (Matter No. R 2007-02), § 284-37-060, filed 8/1/07, effective 9/1/07.]

Chapter 284-43 WAC

HEALTH CARRIERS AND HEALTH PLANS

WAC

284-43-260	Standards for temporary substitution of contracted network providers—"Locum tenens" providers.
284-43-262	Rule concerning contracted network providers called to active duty military service.

WAC 284-43-260 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. It is a longstanding and widespread practice for contracted network providers to retain substitute providers to take over their professional practices when the contracted network providers are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for contracted network providers to bill and receive payment for the substitute providers' services as though they were provided by the contracted network provider. The contracted network provider generally pays the substitute provider based on an agreement between the contracted network provider and the substitute provider, and the substitute provider has the status of an independent contractor rather than an employee of the contracted network provider. These substitute providers are commonly called "locum tenens" providers.

In order to protect patients and ensure that they benefit from seamless quality care when contractual network providers are away from their practices, and that patients receive quality care from qualified substitute providers, carriers may require substitute providers to provide the information required in subsection (1) of this section.

The following are minimum standards for temporary provider substitution and do not prevent a carrier from entering into other agreed arrangements with its contracted network providers for terms that are less restrictive or more favorable to providers.

Carriers must permit the following categories of contracted network provider to arrange for temporary substitution by a substitute provider: Doctor of medicine, doctor of osteopathic medicine, doctor of dental surgery or dental medicine, doctor of chiropractic, podiatric physician and surgeon, doctor of optometry, doctor of naturopathic medicine and advanced registered nurse practitioner.

(1) At the time of substitution, the substitute provider:

(a) Must have a current Washington license and be legally authorized to practice in this state;

(b) Must provide services under the same scope of practice as the contracted network provider;

(c) Must not be suspended or excluded from any state or federal health care program;

(d) Must have professional liability insurance coverage; and

(e) Must have a current drug enforcement certificate, if applicable.

(2)(a) Carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year.

(b) A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

(3) A carrier may require that the contracted network provider agree to bill for services rendered by the substitute provider using the carrier's billing guidelines, including use of HIPAA compliant code sets, commonly known as the Q-6 modifier, or any other code or modifier that the Centers for Medicare and Medicaid Services (CMS) adopts in the future.

(4) Nothing in this section is intended to prevent the carrier from requiring:

(a) That the contracted network provider require acceptance by the substitute provider of the carrier's fee schedule; or

(b) Acceptance by the substitute provider of the carrier's usual and customary charge as payment in full.

(5) This rule does not apply to Medicare Advantage or other health plans administered by the federal government that require precertification of all providers.

[Statutory Authority: RCW 48.02.060 and 48.43.515. 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.]

WAC 284-43-262 Rule concerning contracted network providers called to active duty military service. In lieu of substitution of a provider during a period of active duty military service longer than sixty continuous days, carriers must provide contracted network providers with the opportunity to return to the carrier's network after the provider's active duty military service is completed.

(1)(a) A carrier must allow the provider a period of at least one hundred twenty days to request a return to contracted network provider status after the provider returns to civilian status.

(b) The one hundred twenty-day period must begin no earlier than the date the provider's period of active duty ends.

(2)(a) As a condition for return to the carrier's network, the carrier may require that the provider provide evidence that he or she meets the carrier's then-current standards for credentialing.

(b) If the provider meets or exceeds the credentialing standards of the carrier and timely requests a return to contracted network provider status, the carrier must grant the request whether or not the carrier's network is otherwise closed.

[Statutory Authority: RCW 48.02.060 and 48.43.515. 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.]

Chapter 284-50 WAC

WASHINGTON DISABILITY INSURANCE REGULATIONS

WAC

284-50-440

Standard disclosure form for individual policies—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance.

WAC 284-50-440 Standard disclosure form for individual policies—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. (1) All disability insurers offering individual policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue

a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to all applicants at the time of solicitation and completion of the application form for coverage. Every insurer must have a mechanism in place to verify delivery of the disclosure to the applicant.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed **for approval** with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure document provides a very brief description of the important features of the coverage you are considering. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both you and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), before you purchase this policy you should check with your tax advisor to be sure that you will continue to be eligible to contribute to the HSA if you purchase this coverage.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):
- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370. 07-21-073 (Matter No. R 2007-05), § 284-50-440, filed 10/15/07, effective 11/15/07.]

Chapter 284-51 WAC

STANDARDS FOR COORDINATION OF BENEFITS

WAC

284-51-190	Purpose.
284-51-195	Definitions.
284-51-200	Use of model COB contract provision.
284-51-205	Rules for coordination of benefits.
284-51-210	Coordination procedures.
284-51-215	Time limit.
284-51-220	Facility of payment.
284-51-225	Right of recovery.
284-51-230	Procedure to be followed by secondary plan to calculate benefits and pay a claim.
284-51-235	Notice to covered persons.
284-51-240	Small claim waivers.
284-51-245	Miscellaneous provisions.
284-51-250	Applicability and scope—Effective date for existing contracts.
284-51-255	Appendix A—Model COB contract provisions.
284-51-260	Appendix B—Consumer explanatory booklet.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

284-51-010	Purpose and scope. [Statutory Authority: RCW 48.01.-200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-010, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-010, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-060	Claim determination period. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-060, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-060, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-015	Amount of reduction allowed. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-015, filed 10/3/94, effective 11/3/94.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-075	Order of benefit determination. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-075, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-075, filed 11/4/86, effective 1/1/87.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-020	Required provisions for coordination of benefits. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-020, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-020, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-080	Determination of length of coverage. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-080, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-030	Benefits subject to coordination. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-030, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-030, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-090	Coordination procedures. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-090, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-040	"Plan" defined. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-040, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-040, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-100	Time limit. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-100, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-045	"Preventive care" defined. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-045, filed 10/3/94, effective 11/3/94.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.	284-51-110	Small claim waivers. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-110, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
284-51-050	Allowable expense. [Statutory Authority: RCW 48.01.-200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-050, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060 (3)(a), 48.44.050 and 48.46.200. 91-18-026 (Order R 91-6), § 284-51-050, filed 8/23/91, effective 9/23/91.	284-51-120	Facility of payment. [Statutory Authority: RCW 48.01.-200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-120, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-120, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
		284-51-130	Right of recovery. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-130, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-130, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
		284-51-140	Right to receive and release necessary information. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a), 94-20-068 (Order R 94-15), § 284-51-140, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-140, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
		284-51-150	Disclosure of coordination. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a),

- 94-20-068 (Order R 94-15), § 284-51-150, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-150, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-170 Effective date. [Statutory Authority: RCW 48.01.200, 48.21.200, 48.01.030 and 48.02.060 (3)(a). 94-20-068 (Order R 94-15), § 284-51-170, filed 10/3/94, effective 11/3/94. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 81-14-001 (Order R 81-2), § 284-51-170, filed 6/18/81, effective 1/1/82.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.
- 284-51-185 Appendix B, form for "effect on benefits" provision. [Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 86-22-051 (Order R 86-6), § 284-51-185, filed 11/4/86, effective 1/1/87.] Repealed by 07-13-008 (Matter No. R 2005-07), filed 6/8/07, effective 7/9/07. Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200.

WAC 284-51-190 Purpose. (1) The purpose of this chapter is to:

- (a) Establish a uniform order of benefit determination under which plans pay claims;
 - (b) Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, under rules established by this chapter, do not have to pay their benefits first; and
 - (c) Provide greater efficiency in the processing of claims when a person is covered under more than one plan.
- (2) This chapter does not require the use of coordination of benefits provisions in a plan. However, if a plan contains any provision for the reduction of benefits payable because of other insurance, it must be consistent with the requirements of this chapter. A plan of coverage designed to be supplementary over the underlying basic plan of coverage may provide coverage that is excess to the basic plan of coverage.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-190, filed 6/8/07, effective 7/9/07.]

WAC 284-51-195 Definitions. As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise:

(1) "Allowable expense," except as outlined below means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, totals the higher of the allowable expenses. In no event will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A and Part B or Part C are primary, Medicare's allowable amount is the highest allowable expense.

(a) If an issuer is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established according to Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any

health care expense incurred that may not be subject to the deductible as described in Section 223 (c)(2)(C) of the Internal Revenue Code of 1986.

(b) An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

(c) The following are examples of expenses that are not allowable expenses:

(i) If a person is confined in a private hospital room, the difference between the cost of a semiprivate room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(ii) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

(iii) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense must include similar expenses to which COB applies.

(e) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(2) "Birthday" refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(3) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- (a) Services (including supplies);
- (b) Payment for all or a portion of the expenses incurred;
- (c) A combination of (a) and (b) of this subsection; or
- (d) An indemnification.

(4) "Claim determination period" means calendar year.

(5) "Closed panel plan" means a plan that provides health benefits to covered persons in the form of services primarily through a panel of providers that are employed by the plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(6) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation according to federal law.

(7) "Coordination of benefits" or "COB" means a provision establishing the order that plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(8) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation; or

(c) In cases where a court decree awards more than half of the calendar year's residential time to one parent without the use of "custodial" terminology, the parent to whom the greater residential time is awarded.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10)(a) "Hospital indemnity benefits" or "hospital fixed payment plan" means benefits not related to expenses incurred.

(b) "Hospital indemnity benefits" or "hospital fixed payment plan" does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(11) "Issuer" means a disability carrier, health care service contractor, health maintenance organization, and any other entity issuing a plan as defined in this chapter.

(12) "Plan" means a form of coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(a) If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subsection.

(b) "Plan" includes:

(i) Group, individual or blanket disability insurance contracts, and group or individual contracts marketed by issuers as defined in this chapter;

(ii) Closed panel plans or other forms of group or individual coverage;

(iii) The medical care components of long-term care contracts, such as skilled nursing care; and

(iv) Medicare or other governmental benefits, as permitted by law, except as provided in (c)(vii) of this subsection. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(c) "Plan" does not include:

(i) Hospital indemnity or fixed payment coverage benefits or other fixed indemnity or payment coverage;

(ii) Accident only coverage;

(iii) Specified disease or specified accident coverage;

(iv) Limited benefit health coverage, as defined in WAC 284-50-370;

(v) School accident and similar coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(vi) Benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts

that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(vii) Medicare supplement policies;

(viii) A state plan under Medicaid;

(ix) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;

(x) Automobile insurance policies required by statute to provide medical benefits;

(xi) Benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined at section 3, chapter 267, Laws of 2007.

(13) "Policyholder" means the primary insured named in a nongroup insurance policy.

(14) "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan subject to this chapter is a primary plan if:

(a) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or

(b) All plans that cover the person use the order of benefit determination rules required by this chapter, and under those rules the plan determines its benefits first.

(15) "Secondary plan" means a plan that is not a primary plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-195, filed 6/8/07, effective 7/9/07.]

WAC 284-51-200 Use of model COB contract provision. (1) WAC 284-51-255, Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of subsections (2), (3), and (4) of this section and to the provisions of this chapter.

(2) WAC 284-51-260, Appendix B is a plain language description of the COB process that explains to the covered person how health plans will implement coordination of benefits. It is not intended to replace or change the provisions that are in the contract. Its purpose is to explain the process to be used by two or more plans to pay for or provide benefits as allowed by the provisions of this chapter.

(3) Issuers need not use the specific words and format provided in WAC 284-51-255 and the plain language explanation in WAC 284-51-260. Editing changes may be made by the issuer to fit the language and style of the rest of its contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. Modifications may be made provided they do not conflict with the requirements of this chapter.

(4) A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person could have been covered under another plan; or

(c) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

(5) No plan may contain a provision that its benefits are "always excess" or "always secondary" except under the rules permitted in this chapter.

(6) No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan as defined in this chapter.

(7) If a person has met the requirements for coverage under the primary plan, a closed panel plan in secondary position must pay benefits as if the covered person had met the requirements of the closed panel plan. Further, coordination of benefits may occur during the claim determination period even where there are no savings in the closed panel plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-200, filed 6/8/07, effective 7/9/07.]

WAC 284-51-205 Rules for coordination of benefits.

(1) When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

(a) The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

(b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(c) When multiple contracts providing coordinated coverage are treated as a single plan under this chapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one issuer pays or provides benefits under the plan, the issuer designated as primary within the plan is responsible for the plan's compliance with this chapter.

(d) If a person is covered by more than one secondary plan, the order of benefit determination rules of this chapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this chapter, has its benefits determined before those of that secondary plan.

(2)(a) Except as provided in (b) of this subsection, a plan that does not contain order of benefit determination provisions that are consistent with this chapter is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary.

(b) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(3) A plan may take into consideration the benefits paid or provided by another plan only when, under the rules of this chapter, it is secondary to that other plan.

(4) Order of benefit determination. Each plan determines its order of benefits using the first of the following rules that applies:

(a) Nondependent or dependent.

(i) Subject to (a)(ii) of this subsection, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(ii)(A) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(I) Secondary to the plan covering the person as a dependent; and

(II) Primary to the plan covering the person as other than a dependent (e.g., a retired employee);

(B) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child must determine the order of benefits as follows:

(i) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

(ii) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

(A) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision;

(B) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(C) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (b)(i) of this subsection determine the order of benefits;

(D) If a court decree states that the parents have joint custody without specifying that one parent has financial responsibility or responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (b)(i) of this subsection determine the order of benefits; or

(E) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:

- (I) The plan covering the custodial parent, first;
- (II) The plan covering the custodial parent's spouse, second;
- (III) The plan covering the noncustodial parent, third; and then
- (IV) The plan covering the noncustodial parent's spouse, last.

(iii) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable, under (b)(i) or (ii) of this subsection as if those individuals were parents of the child.

(c) Active employee or retired or laid-off employee.

(i) The plan that covers a person as an active employee that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

(ii) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(d) COBRA or state continuation coverage.

(i) If a person whose coverage is provided under COBRA or under a right of continuation according to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person under COBRA or under a right of continuation according to state or other federal law is the secondary plan.

(ii) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(iii) This provision does not apply if the provision in (a) of this subsection can determine the order of benefits.

(e) Longer or shorter length of coverage.

(i) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

(ii) To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended.

(iii) The start of a new plan does not include:

- (A) A change in the amount or scope of a plan's benefits;
- (B) A change in the entity that pays, provides or administers the plan's benefits; or
- (C) A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

(iv) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the

date the person first became a member of the group must be used as the date to determine the length of time the person's coverage under the present plan has been in force.

(f) If none of the preceding rules determines the order of benefits, the allowable expenses must be shared equally between the plans.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-205, filed 6/8/07, effective 7/9/07.]

WAC 284-51-210 Coordination procedures. Issuers must use the following claims administration practices to expedite claim payments where coordination of benefits is involved:

(1) Claim personnel must participate in continuing education programs.

(2) All requests for information must be handled in an accurate and prompt manner by the inquiring issuer and the responding issuer, including the disclosure of the amounts allowed and paid or to be paid by the primary plan for each claim.

(3) Claim personnel of all issuers, whether primary or secondary, must make every reasonable effort, including use of the telephone or e-mail, to speed up exchange of coordination of benefits information. Delay of payment for lack of complete coordination of benefits information does not constitute a reasonable effort and compliance with WAC 284-51-215 is required.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-210, filed 6/8/07, effective 7/9/07.]

WAC 284-51-215 Time limit. Each issuer must establish time limits for payment of a claim and may not unreasonably delay payment through the application of a coordination of benefits provision. Time limits established by a primary plan must be no less favorable than those contained in WAC 284-43-321. Any time limit established by a secondary plan that is in excess of ninety days from receipt of a claim will be considered unreasonable. When payment is necessarily delayed for reasons other than the application of a coordination of benefits provision, investigation of other plan coverage must be conducted concurrently to avoid delay in the ultimate payment of benefits. Any issuer that is required by the time limit to make payment as the primary plan because it has insufficient information to make it a secondary plan may exercise its rights under its "right of recovery" provision for recovery of any excess payments. Any issuer that is knowingly responsible for payment as the secondary plan must make a reasonable estimate of the primary plan payment and base its secondary payment on that amount. After payment information is received from the primary plan, the secondary plan may recover any excess amount paid under its "right of recovery" provision.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-215, filed 6/8/07, effective 7/9/07.]

WAC 284-51-220 Facility of payment. A plan providing for coordination of benefits must contain a "facility of payment" provision substantially as follows: "If payments

that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. To the extent of such payments, the issuer is fully discharged from liability under this plan."

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-220, filed 6/8/07, effective 7/9/07.]

WAC 284-51-225 Right of recovery. A plan providing for coordination of benefits must contain a "right of recovery" provision substantially as follows: "The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person, other issuer or plan that has received payment.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-225, filed 6/8/07, effective 7/9/07.]

WAC 284-51-230 Procedure to be followed by secondary plan to calculate benefits and pay a claim. (1) In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total allowable expense for that claim. However, in no event shall the secondary carrier be required to pay an amount in excess of its maximum benefit plus accrued savings. In no event should the enrollee be responsible for a deductible amount greater than the highest of the two deductibles.

(2) If a plan by its terms contains gatekeeper requirements as defined in subsection (3) of this section, and a person fails to comply with such requirements, these provisions will have the following effect in the absence of an alternative procedure agreed upon between both plans and the covered person:

(a) If the plan is secondary, all secondary gatekeeper requirements will be waived if the gatekeeper requirements of the primary plan have been met.

(b) If the primary plan becomes secondary during a course of treatment, the new primary plan must make reasonable provision for continuity of care if one or more treating providers are not in the new primary plan's network.

(3) For the purpose of this section, "gatekeeper requirements" means any requirement that an otherwise eligible person must fulfill prior to receiving the benefits of a plan. These requirements include but are not limited to use of network providers, prior authorization, primary care physician referrals, or other similar case management requirements.

(4) When a plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period do not exceed one hundred percent of the total allowable expenses. The secondary plan must calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary. These savings are recorded as a benefit reserve

for the covered person and must be used by the secondary plan to pay any allowable expenses not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the issuer of the secondary plan must:

(a) Determine its obligation under its plan;

(b) Determine whether a benefit reserve has been recorded for the covered person; and

(c) Determine whether there are any unpaid allowable expenses during that claims determination period.

(d) Use any amount that has accrued in the covered person's recorded benefit reserve to make payment so that one hundred percent of the total allowable expenses incurred are paid during the claim determination period.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-230, filed 6/8/07, effective 7/9/07.]

WAC 284-51-235 Notice to covered persons. A plan must include the following statement in the enrollee contract or booklet provided to covered persons: "If you are covered by more than one health benefit plan, you or your provider should file all your claims with each plan at the same time. If Medicare is your primary plan, Medicare may submit your claims to your secondary carrier for you."

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-235, filed 6/8/07, effective 7/9/07.]

WAC 284-51-240 Small claim waivers. In appropriate cases, issuers are encouraged to waive the investigation of possible other plan coverage on claims less than fifty dollars. However, if additional liability is incurred which raises the claim above fifty dollars, the entire liability may be included in the coordination of benefits computation.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-240, filed 6/8/07, effective 7/9/07.]

WAC 284-51-245 Miscellaneous provisions. (1) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision requires a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

(2)(a) A plan with order of benefit determination rules that comply with this chapter (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this chapter (non-complying plan) on the following basis:

(i) If the complying plan is the primary plan, it must pay or provide its benefits first;

(ii) If the complying plan is the secondary plan under the order of benefit determination in this chapter, it must pay or provide its benefits first, but the amount of the benefits payable must be determined as if the complying plan were the

secondary plan. In this situation, the payment is the limit of the complying plan's liability; and

(iii) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within forty-five days after the date on the letter making the request, the complying plan may assume the benefits of the noncomplying plan are identical to its own, and pay its benefits accordingly. If, within twenty-four months after payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it must adjust payments accordingly between the plans.

(b) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation outlined below, then the complying plan may advance to the covered person or on behalf of the covered person an amount equal to the difference.

(c) In no event may the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan must be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

(3) COB differs from subrogation. Provisions for one may be included in plans without compelling the inclusion or exclusion of the other.

(4) If the plans cannot agree on the order of benefits within thirty calendar days after the plans have received the information needed to pay the claim, the plans must immediately pay the claim in equal shares and determine their relative liabilities following payment. No plan is required to pay more than it would have paid had it been the primary plan.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-245, filed 6/8/07, effective 7/9/07.]

WAC 284-51-250 Applicability and scope—Effective date for existing contracts. This chapter applies to all plans, as defined in WAC 284-51-195 that are issued, amended or renewed after December 31, 2007. All plans issued prior to January 1, 2008 must be compliant with this chapter on that date.

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-250, filed 6/8/07, effective 7/9/07.]

WAC 284-51-255 Appendix A—Model COB contract provisions.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The coordination of benefits (COB) provision applies when a person has health care coverage under more than one **plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **plan** will pay a claim for benefits. The **plan**

that pays first is called the **primary plan**. The **primary plan** must pay benefits according to its policy terms without regard to the possibility that another **plan** may cover some expenses. The **plan** that pays after the **primary plan** is the **secondary plan**. The **secondary plan** may reduce the benefits it pays so that payments from all **plans** do not exceed 100% of the total **allowable expense**.

DEFINITIONS

A. A **plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) **Plan** includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) **Plan** does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **plan**. If a **plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **plan**.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether **this plan** is a **primary plan** or **secondary plan** when the person has health care coverage under more than one **plan**.

When **this plan** is primary, it determines payment for its benefits first before those of any other **plan** without considering any other **plan's** benefits. When **this plan** is secondary, it determines its benefits after those of another **plan** and must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100% of the **total allowable expense** for that claim. This means that when **this plan** is **secondary**, it must pay the amount which, when combined with what the **primary plan** paid, totals 100% of the

highest **allowable expense**. In addition, if this **plan** is **secondary**, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the **primary plan**) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that calendar year, whether or not they are an **allowable expense** under this **plan**. If this **plan** is **secondary**, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

D. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **plan** covering the person. When a **plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **allowable expense** and a benefit paid. An expense that is not covered by any **plan** covering the person is not an **allowable expense**.

The following are examples of expenses that are not **allowable expenses**:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an **allowable expense**, unless one of the **plans** provides coverage for private hospital room expenses.

(2) If a person is covered by two or more **plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an **allowable expense**.

(3) If a person is covered by two or more **plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **allowable expense**.

E. **Closed panel plan** is a **plan** that provides health care benefits to covered persons in the form of services through a panel of providers who are primarily employed by the **plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more **plans**, the rules for determining the order of benefit payments are as follows:

A. The **primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **plan**.

B. (1) Except as provided in subsection (2), a **plan** that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both **plans** state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the **plan** provided by the contract holder. Examples include major medical coverages that are superimposed over hospital and surgical benefits, and

insurance type coverages that are written in connection with a **closed panel plan** to provide out-of-network benefits.

C. A **plan** may consider the benefits paid or provided by another **plan** in calculating payment of its benefits only when it is secondary to that other **plan**.

D. Each **plan** determines its order of benefits using the first of the following rules that apply:

(1) Non-dependent or dependent. The **plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **primary plan** and the **plan** that covers the person as a dependent is the **secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **plan** covering the person as a dependent, and primary to the **plan** covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two **plans** is reversed so that the **plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **secondary plan** and the other **plan** is the **primary plan**.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **plan** the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The **plan** of the parent whose birthday falls earlier in the calendar year is the **primary plan**; or

- If both parents have the same birthday, the **plan** that has covered the parent the longest is the **primary plan**.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **plan** of that parent has actual knowledge of those terms, that **plan** is primary. This rule applies to claim determination periods commencing after the **plan** is given notice of the court decree;

(ii) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;

(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or

(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The **plan** covering the **custodial parent**, first;
- The **plan** covering the spouse of the **custodial parent**, second;
- The **plan** covering the **noncustodial parent**, third; and then

- The **plan** covering the spouse of the **noncustodial parent**, last

(c) For a dependent child covered under more than one **plan** of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The **plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **primary plan**. The **plan** covering that same person as a retired or laid-off employee is the **secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another **plan**, the **plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **primary plan** and the COBRA or state or other federal continuation coverage is the **secondary plan**. If the other **plan** does not have this rule, and as a result, the **plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The **plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **primary plan** and the **plan** that covered the person the shorter period of time is the **secondary plan**.

(6) If the preceding rules do not determine the order of benefits, the **allowable expenses** must be shared equally between the **plans** meeting the definition of **plan**. In addition, **this plan** will not pay more than it would have paid had it been the **primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

When **this plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **plans** during a claim determination period are not more than the total **allowable expenses**. In determining the amount to be paid for any claim, the **secondary plan** must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal one hundred percent of the total **allowable expense** for that claim **total allowable expense** is the highest **allowable expense** of the **primary plan** or the **secondary plan**. In addition, the **secondary plan** must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **this plan** and other **plans**. [Organization

responsibility for **COB** administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **this plan** and other **plans** covering the person claiming benefits. [Organization responsibility for **COB** administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under **this plan** must give [organization responsibility for **COB** administration] any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If payments that should have been made under **this plan** are made by another **plan**, the issuer has the right, at its discretion, to remit to the other **plan** the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other **plan** are considered benefits paid under **this plan**. To the extent of such payments, the issuer is fully discharged from liability under **this plan**.

RIGHT OF RECOVERY

The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-255, filed 6/8/07, effective 7/9/07.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-51-260 Appendix B—Consumer explanatory booklet.

COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all of the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits issuers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of

some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the "primary" or "secondary" benefit payer. The primary plan always pays first when you have a claim.

Any plan that does not contain your state's COB rules will always be primary.

When This Plan is Primary

If you or a family member is covered under another plan in addition to this one, we will be primary when:

Your Own Expenses

- The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

- The claim is for your spouse, who is covered by Medicare, and you are not both retired.
- **Your child's expenses.** The claim is for the health care expenses of your child who is covered by this plan; and
- You are married and your birthday is earlier in the year than your spouse's or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual's birthday. This is known as the "birthday rule"; or
- You are separated or divorced and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- There is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits according to the terms of your contract, just as if you had no other health care coverage under any other plan.

How We Pay Claims When We Are Secondary

When we are knowingly the secondary plan, we will make a reasonable estimate of the primary plan payment and base our payment on that amount. After payment information is received from the primary plan, we may recover from the primary plan any excess amount paid under the "right of recovery" provision in the plan. We may not delay our payments because of lack of information from the primary plan. We are required to pay claims within ninety days of receipt.

- If there is a difference between the amounts the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of

the primary plan, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other plans.

- We will determine our payment by subtracting the amount we estimate that the primary plan will pay from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal to one hundred percent of the total allowable expense (the highest of the amounts allowed under each plan involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the plan(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid. For example, if the primary plan covers similar kinds of health care expenses, but allows expenses that we do not cover, we may pay for those expenses.

Questions About Coordination of Benefits? Contact Your State Insurance Department

[Statutory Authority: RCW 48.20.60 [48.20.060], 48.21.200, 48.44.050, and 48.46.200. 07-13-008 (Matter No. R 2005-07), § 284-51-260, filed 6/8/07, effective 7/9/07.]

Chapter 284-66 WAC

WASHINGTON MEDICARE SUPPLEMENT INSURANCE REGULATION

WAC

284-66-063	Benefit standards for policies or certificates issued or delivered after June 30, 1992.
284-66-066	Standard Medicare supplement benefit plans.
284-66-092	Form of "outline of coverage."
284-66-142	Form of replacement notice.
284-66-160	Adjustment notice to conform existing Medicare supplement policies to changes in Medicare.

WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termina-

tion of coverage of the insured, other than the nonpayment of premium.

(c) Each Medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the Medicare supplement policy is terminated by the group policy holder and is not replaced as provided under (c)(v) of this subsection, the issuer must offer certificateholders an individual Medicare supplement policy that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificateholder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(d) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(e) If a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(f)(i) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate must be automatically reinstituted effective as of the date of termination of the entitlement if the pol-

icyholder or certificateholder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period.

(iii) Each Medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(g) Reinstitution of the coverages;

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(2) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(3) Standards for additional benefits. The following additional benefits must be included in Medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(a) Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A;

(c) Medicare Part B deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty percent of the Medicare Part B excess charges: Coverage for eighty percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a Medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by Medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in *American Medical Association Current Procedural Terminology (AMA CPT)* codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by Medicare.

(j) At-home recovery benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services that assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by Medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

(4) Standardized Medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under Medicare Parts A and B for the balance of the calendar

year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(5) Standardized Medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

[Statutory Authority: RCW 48.06.060 and 48.66.165, 07-06-014 (Matter No. R 2006-13), § 284-66-063, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165, 05-17-019 (Matter No. R 2004-08), § 284-66-063, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165, 96-09-047 (Matter No. R 96-2), § 284-66-063, filed 4/11/96, effective 5/12/96. Statutory Authority: RCW 48.02.-060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200, 92-06-021 (Order R 92-1), § 284-66-063, filed 2/25/92, effective 3/27/92.]

WAC 284-66-066 Standard Medicare supplement benefit plans. (1) An issuer must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3), (4) or (5) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized Medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible as defined in WAC 284-66-063 (3)(a).

(c) Standardized Medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), and (h), respectively.

(d) Standardized Medicare supplement plan "D" consists of only the following: The core benefit, as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (h), and (j), respectively.

(e) Standardized Medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in WAC 284-66-063 (3)(a), (b), (h), and (i), respectively.

(f) Standardized Medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e), and (h), respectively.

(g) Standardized Medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized Medicare supplement benefit plan "G" consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (d), (h), and (j), respectively.

(i) Standardized Medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3)(a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(j) Standardized Medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in

WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(k) Standardized Medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-063 (3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(6) Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized Medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063(4).

(b) Standardized Medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063(5).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available,

cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-066, filed 2/26/07, effective 3/29/07. Statutory

Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-066, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-066, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-066, filed 2/25/92, effective 3/27/92.]

WAC 284-66-092 Form of "outline of coverage." (1) Cover page.

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s)___[insert letter(s) of plan(s) being offered]

See Outlines of Coverage sections for details about ALL plans

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits for Plans A-J

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A	B	C	D	E	F/F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as plans F and J after one has paid a calendar year [\$] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[Company Name] does not offer the [high deductible plan F] [high deductible plan J] [high deductible plan F or J].

[COMPANY NAME]

Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventative Services

J	K**	L**
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	\$[] Out-of-Pocket Annual Limit***	\$[] Out-of-Pocket Annual Limit***

**Plan K and L provide for different cost-sharing for items and services A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

(2) Disclosure page(s):

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state.

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts as noted in WAC 284-66-066(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

(3) Charts displaying the feature of each benefit plan offered by the issuer:

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --- While using 60 lifetime reserve days --- Once lifetime reserve days are used: --- Additional 365 days --- Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$0 \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$[] (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 \$0 \$0	\$0 Up to \$[] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$[] (Part B deductible) \$0 All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[] of Medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN A
PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment			
First \$[] of Medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[]	\$[] (Part A deductible)	\$0
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			
- - - While using 60 lifetime reserve days	All but \$[] a day	\$[] a day	\$0
- - - Once lifetime reserve days are used:			
- - - Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
- - - Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	\$0	Up to \$[] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN B
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[] (Part B deductible) \$0
---	--------------------	-------------------	---

PLAN C
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[] /day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% \$0	\$0 \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN C
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$[] (Part B deductible) 20%	\$0 \$0 \$0
---	----------------------------	---	-----------------------

PLAN C (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan - - - Benefit for each visit - - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit) - - - Calendar year maximum	100% \$0 80% \$0 \$0 \$0	\$0 \$0 20% Actual charges to \$40 a visit Up to the number of Medicare approved visits, not to exceed 7 each week \$1,600	\$0 \$[] (Part B deductible) \$0 Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN E
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN E
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[] (Part B deductible) \$0
---	--------------------	-------------------	---

PLAN E (continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
 MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
 [**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscella- neous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including hav- ing been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doc- tor certifies you are termi- nally ill and you elect to receive these ser- vices	All but very limited coinsur- ance for outpatient drugs and inpatient respite care	\$0	Balance

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN F] [HIGH DEDUCTIBLE PLAN F]
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
 [**This high deductible plan pays the same benefits as plan F after one has paid a calendar year \$[] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCT- IBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN F] [HIGH DEDUCTIBLE PLAN F]

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$[] (Part B deductible) 20%	\$0 \$0 \$0

PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE, **] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	 All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	 \$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	 \$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but \$[]/day \$0	 \$0 Up to \$[] a day \$0	 \$0 \$0 All costs
BLOOD First 3 pints Additional amounts	 \$0 100%	 3 pints \$0	 \$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	 \$0	 Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	 \$0 Generally 80% \$0	 \$0 Generally 20% 80%	 \$[] (Part B deductible) \$0 20%

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[] of Medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G (continued)
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment			
First \$[] of Medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN H
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[]	\$[] (Part A deductible)	\$0
61st thru 90th day	All but \$[] a day	\$[] a day	\$0
91st day and after:			

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
--- While using 60 lifetime reserve days --- Once lifetime reserve days are used: --- Additional 365 days --- Beyond the additional 365 days	All but \$[] a day \$0 \$0	\$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 0%	\$[] (Part B deductible) \$0 All costs
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN H
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First \$[] of Medicare approved amounts*	\$0	\$0	\$[] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	\$0

PLAN H (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges	\$0		

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$[] (Part B deductible) \$0 \$0
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN I (continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan - - - Benefit for each visit	100% \$0 80% \$0	\$0 \$0 20% Actual charges to \$40 a visit	\$0 \$[] (Part B deductible) \$0 Balance
---	---------------------------	---	--

--- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medi- care approved visits, not to exceed 7 each week	
--- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care ser- vices beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250 20% and amounts over the \$50,000 lifetime maximum
Remainder of charges*	\$0	80% to a lifetime maximum benefit of \$50,000	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Parts A and B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: --- While using 60 lifetime reserve days --- Once lifetime reserve days are used: --- Additional 365 days --- Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (Part A deductible) \$[] a day \$[] a day 100% of Medicare eligi- ble expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's require- ments, including having been in a hos- pital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

[PLAN J] [HIGH DEDUCTIBLE PLAN J]

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as plan J after one has paid a calendar year \$[] deductible. Benefits from high deductible plan J will not begin until out-of-pocket expenses are \$[]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and B, but does not include the plan's separate foreign travel emergency deductible]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts* Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 80% \$0	\$[] (Part B deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$[] of Medicare approved amounts* Remainder of Medicare approved amounts	\$0 \$0 80%	All costs \$[] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

[PLAN J] [HIGH DEDUCTIBLE PLAN J] (continued)

PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts*	100% \$0	\$0 \$[] (Part B deductible)	\$0 \$0

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
Remainder of Medicare approved amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
- - - Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
- - - Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
- - - Calendar year maximum	\$0	\$1,600	

[PLAN J] [HIGH DEDUCTIBLE PLAN J]
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days	All but \$[] All but \$[] a day	\$[] (50% of Part A deductible) \$[] a day	\$[] (50% of Part A deductible)◆ \$0
	All but \$[] a day	\$[] a day	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
--- Once lifetime reserve days are used:			
--- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
--- Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[]/day	Up to \$[] a day	Up to \$[] a day◆
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	50%	50%◆
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments◆

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

****Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts****	\$0	\$0	\$[] (Part B deductible)****◆ All costs above Medicare approved amounts
Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts	Generally 75% or more of Medicare approved amounts Generally 80%	Remainder of Medicare approved amounts Generally 10%	 Generally 10%◆ All costs (and they do not count toward annual out-of-pocket limit of \$[])*
Part B excess charges (Above Medicare approved amounts)	\$0	\$0	
BLOOD			
First 3 pints	\$0	50%	50%◆
Next \$[] of Medicare approved amounts****	\$0	\$0	\$[] (Part B deductible)****◆
Remainder of Medicare approved amounts	Generally 80%	Generally 10%	Generally 10%◆
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K (continued)
PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- - - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- - - Durable medical equipment First \$[] of Medicare approved amounts*****	\$0	\$0	\$[] (Part B deduct- ible)◆
Remainder of Medicare approved amounts	80%	10%	10%◆

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

*You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[] each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - - - While using 60 lifetime reserve days - - - Once lifetime reserve days are used: - - - Additional 365 days - - - Beyond the additional 365 days	All but \$[] All but \$[] a day All but \$[] a day \$0 \$0	\$[] (75% of Part A deductible) \$[] a day \$[] a day 100% of Medicare eligible expenses \$0	\$[] (25% of Part A deductible)◆ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's require- ments, including having been in a hos- pital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$[]/day \$0	\$0 Up to \$[] a day \$0	\$0 Up to \$[] a day◆ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%◆ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eli- gible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments◆

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN L
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

***Once you have been billed \$[] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY *
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[] of Medicare approved amounts**** Preventative Benefits for Medicare covered services Remainder of Medicare approved amounts Part B excess charges (Above Medicare approved amounts)	\$0 Generally 75% or more of Medicare approved amounts Generally 80% \$0	\$0 Remainder of Medicare approved amounts Generally 15% \$0	\$[] (Part B deductible)****◆ All costs above Medicare approved amounts Generally 5%◆ All costs (and they do not count toward annual out-of-pocket limit of \$[])*
BLOOD First 3 pints Next \$[] of Medicare approved amounts**** Remainder of Medicare approved amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25%◆ \$[] (Part B deductible)****◆ Generally 5%◆
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

PLAN L (continued)
PARTS A & B

SERVICE	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - - - Medically necessary skilled care services and medical supplies - - - Durable medical equipment First \$[] of Medicare approved amounts**** Remainder of Medicare approved amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$[] (Part B deductible)◆ 5%◆

****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-092, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-092, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060. 92-17-078 (Order R 92-7), § 284-66-092, filed 8/19/92, effective 9/19/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.-020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-092, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-142 Form of replacement notice.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF
MEDICARE SUPPLEMENT INSURANCE OR MEDICARE
ADVANTAGE**

[Insurance company's name and address]

SAVE THIS NOTICE!

IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company name] Insurance Company. Your new policy will provide thirty days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other disability coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers]
- Other. (please specify)

1. NOTE: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. If you have had your current Medicare supplement policy less than three months, health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

.....
(Signature of Agent, Broker, or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

.....
(Applicant's Signature)

.....
(Date)

*Signature not required for direct response sales.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-142, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-142, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. 96-09-047 (Matter No. R 96-2), § 284-66-142, filed 4/11/96, effective 5/12/96. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-142, filed 2/25/92, effective 3/27/92.]

Reviser's note: The brackets and enclosed material in the text of the above section occurred in the copy filed by the agency.

WAC 284-66-160 Adjustment notice to conform existing Medicare supplement policies to changes in Medicare. As soon as practicable, but no later than thirty days before the effective date of any Medicare benefit changes, every issuer providing Medicare supplement insurance coverage to a resident of this state must notify its insureds of modifications it has made to Medicare supplement policies. The adjustment notice is intended to be informational only and for the sole purpose of informing policyholders and certificate holders about changes in Medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The form of an adjustment notice provided to residents of this state must be filed with the commissioner before being used.

(1) The notice must include a description of revisions to the Medicare program and a description of each modification

made to the coverage provided under the Medicare supplement insurance policy.

(2) The notice must inform each covered person of the approximate date when premium adjustments due to changes in Medicare benefits will be made.

(3) The notice of benefit modifications and any premium changes must be furnished in outline form and in clear and simple terms so as to facilitate comprehension.

(4) The notice must not contain or be accompanied by any solicitation.

(5) Issuers must comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

[Statutory Authority: RCW 48.06.060 and 48.66.165. 07-06-014 (Matter No. R 2006-13), § 284-66-160, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. 05-17-019 (Matter No. R 2004-08), § 284-66-160, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. 92-06-021 (Order R 92-1), § 284-66-160, filed 2/25/92, effective 3/27/92. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130, 48.46.200, 48.66.041, 48.66.050, 48.66.100, 48.66.110, 48.66.120, 48.66.130, 48.66.150 and 48.66.160. 90-07-059 (Order R 90-4), § 284-66-160, filed 3/20/90, effective 4/20/90.]

Chapter 284-96 WAC

GROUP AND BLANKET DISABILITY INSURANCE

WAC

284-96-550

Standard disclosure form for group coverage—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance.

WAC 284-96-550 Standard disclosure form for group coverage—Illness-triggered fixed payment insurance, hospital confinement fixed payment insurance, or other fixed payment insurance. (1) All disability insurers offering group policies that provide benefits in the form of illness-triggered fixed payments, hospital confinement fixed payments or other fixed payment insurance, must issue a disclosure form in substantially the format and content outlined below. The disclosure form must be provided to the master policyholder at the time of solicitation and completion of the application form and to all enrollees at the time of enrollment. Every insurer must have a mechanism in place to verify delivery of the disclosure to the master policyholder and to every enrollee.

(2) The type size and font of the disclosure form must be easily read and be no smaller than 10 point.

(3) The insurer's disclosure form must be filed **for approval** with the commissioner prior to use.

(4) The standard disclosure form replaces any outline of coverage that would otherwise be required for fixed payment policies and must include, at a minimum, the following information:

(Insurer's name and address)

IMPORTANT INFORMATION ABOUT THE COVERAGE YOU ARE BEING OFFERED

Save this statement! It may be important to you in the future. The Washington State Insurance Commissioner

requires that we give you the following information about fixed payment benefits.

This coverage is not comprehensive health care insurance and will not cover the cost of most hospital and other medical services.

This disclosure provides a very brief description of the important features of the coverage being considered. It is not an insurance contract and only the actual policy provisions will control. The policy itself will include in detail the rights and obligations of both the master policyholder and (insurer's name).

This coverage is designed to pay you a fixed dollar amount regardless of the amount that the provider charges. Payments are not based on a percentage of the provider's charge and are paid in addition to any other health plan coverage you may have.

CAUTION: If you are also covered under a High Deductible Health Plan (HDHP) and are contributing to a Health Savings Account (HSA), you should check with your tax advisor or benefit advisor prior to purchasing this coverage to be sure that you will continue to be eligible to contribute to the HSA if this coverage is purchased.

The benefits under this policy are summarized below.

- Type of coverage:
- Benefit amount:
- Benefit trigger (identify any periods of no coverage such as eligibility or waiting periods):
- Duration of coverage:
- Renewability of coverage:

Policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described above include the following:

(List all exclusions including those that relate to limitations for preexisting conditions.)

[Statutory Authority: RCW 48.02.060, 48.20.550, and 48.21.370. 07-21-073 (Matter No. R 2007-05), § 284-96-550, filed 10/15/07, effective 11/15/07.]